
**NEBRASKA
MENTAL HEALTH BOARD TRAINING**

SELF-STUDY HANDBOOK

Division of Behavioral Health Services
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

In Compliance with the Statutory Requirement to Provide Annual Training to Members of Nebraska Mental Health Boards Neb. Rev. Stat. 71-916 or 204 NAC 6 (Nebraska Administrative Code Chapter 6)

Information in this Self-Study Handbook was adapted from presentations at the 1999, 2000, 2001 and 2004 Nebraska Mental Health Board Trainings.

Presenters included:

Richard Fields, M.D., Fields & Associates, Atlanta, GA

Elizabeth Fulton Howell, M.D, Emory University, Atlanta, GA

Alesia McKinlay, M.A., J.D.; Nebraska Advocacy Services

David Babcock, J.D., Chief Legal Counsel, Nebraska Department of Health and Human Services

Sam Kaplan, J. D., Legal Counsel, Nebraska Department of Health and Human Services

Blaine Shaffer, M.D. Chief Clinical Officer, Division of Behavioral Health Services, Nebraska Department of Health and Human Services

Richard A. Fields, M.D. received permission to use portions of training materials from Phillip J. Resnick, M.D., Professor of Psychiatry and Director, Fellowship in Forensic Psychiatry at Case Western Reserve University.

Nebraska Mental Health Board Training
SELF STUDY HANDBOOK

Compiled and edited by:

Vicki B. Blattert, M.S.E., L.M.H.P.

Additional editing by:

Division of Behavioral Health Services Staff

TABLE OF CONTENTS

Self-Study Objectives	5
Excerpts from the Nebraska Mental Health Commitment Act	6
Duty of Board	
Mentally Ill Dangerous Person Defined	
Responsibility of the Mental Health Board	7
Personal Rights of Subjects	15
LB 1199 Summary	19
Precedent Setting Legal Cases	23
Board Determination of Mental Illness	
1. Overview of Mental Illness	25
2. Overview of Substance Abuse versus Substance Dependency .	27
3. Overview of Dual Disorders & Dual Disorder Treatment	28
4. Overview of Co-occurring Disorders & Dual Enhanced Treatment	30
Board Determination of Dangerousness	
1. Magnitude, Likelihood, Imminence, Frequency	32
2. Risk Factors	33
3. Spectrum of Aggressive Behavior	36
4. Danger to Self: Suicide	37
5. Danger to Self: Self Neglect	38
Information Required to Determine Commitment	39
Questions for MH Board Members to Ask at Hearings	41
1. Questions to Ask MH Professionals & LADACs	
2. Questions to Ask Subjects	
The Commitment Decision	42
The Board's Responsibility in Reassessing Level of Care Decisions. .	43
Behavioral Health Reform	44
Conclusion	46
Forced Medication	47
Access by Law Enforcement to Mental Health Board file	48
Statutory Role of Mental Health Board Duties & Responsibilities. . .	49
Immunity	49
Self Study Exam Instructions	51
Self Study Exam	52
References	58

Appendices

A. Nebraska Mental Health Commitment Act.	59
B. Snapshots of Nebraska MH and SA Service Definitions	88
C. Glossary of General Terms	97
D. MH and SA Service Matrix of Public Safety and Service Intensity	101
E. Regional Contact for Local Services and Providers	104
F. Map of Behavioral Health Regions	117
G. Warrant of Arrest Form.	119
H. Mental Health Individualized Treatment Plan	121
I. Warrant of Inpatient Admission Form.	124
J. Outpatient Commitment Order Form.	126
K. Emergency Protective Custody Admissions Procedure for Dangerous Sex Offender .	129
L. LB 1199 Flow Chart	132
M. Transportation Costs Determination Flow Chart	134
N. Mental Health Professional Certificate.	136
O. Emergency Admittance Pursuant to Certificate of a Peace Officer	139

STUDY GUIDE OBJECTIVES:

Provide information for Mental Health Board members to assist in decision-making at commitment hearings

To accomplish the objective, readers will:

- Gain an appreciation of the role of the Mental Health Board in preserving an individual's rights and ensuring due process at Mental Health Board hearings
- Know the implications for Mental Health Board decisions arising from the cases of Olmstead, Wickwire, and Albert
- Become aware of the elements contained in a five Axis diagnosis from the most current edition of DSM (Diagnostic and Statistical Manual of Mental Disorders) and the content of a mental status exam
- Apply the criteria of magnitude, imminence, likelihood and frequency in making determination of dangerousness to self and to the public
- Identify the difference between substance abuse and substance dependency
- Learn the State definition of dual disorder
- Use the statutory requirement for least restrictive level of care, to commit to outpatient/community based services
- Have a list of questions to ask at hearings to gain the clear and convincing proof of mental illness and dangerousness needed to make a commitment decision

Excerpts from the Nebraska Mental Health Commitment Act

71-924

Mental Health Board; duties

A hearing shall be held by the mental health board to determine whether there is **clear and convincing evidence** that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections **71-943** to **71-960** and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section **71-925**. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

Source: laws 1976, LB 806 § 45; Laws 1981, LB 95, § 14; R.S. 1943, (1999), §83-1035; Laws 2004, LB 1083, § 44.

Operative date July 1, 2004.

71-907

Mentally Ill Defined

Mentally ill means have a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.

Source: Laws 1977, LB 204, § 27; R.S. 1943, (1999), § 83-1009.01; Laws 2004, LB 1083, § 27.

Operative date July 1, 2004.

Responsibility of the Mental Health Board

According to **71.924**, the duty of the Mental Health Board is to determine at a hearing whether there is clear and convincing proof that the person before them is a mentally ill and dangerous person.

Further, **71.925** provides that the board must also determine that neither voluntary hospitalization nor less restrictive alternative level of care would prevent harm to themselves or others. The first step in the commitment process is an assessment and clinical decision regarding the presence of mental illness, to which a mental health professional will testify at a hearing. It is important to ask the clinician what other levels of care and services were considered by the treatment team before arriving at the placement recommendation to the board.

If there is a finding of mental illness, the board next makes a legal decision regarding danger to self or others. If criteria for dangerousness are met, a third decision arises, whether commitment to community based/outpatient treatment will satisfy the needs of the person and public safety; or if the choice of last resort, inpatient commitment, is necessary.

The level of evidence needed to make a commitment decision is *clear and convincing evidence*. This is less than the *beyond reasonable doubt* required for a criminal conviction, but more than the *preponderance of the evidence* needed in the usual civil case. The board serves as final decision-maker, determining if a person's civil liberties must be taken from them **temporarily** to protect the person or society in exchange for needed treatment for mental health and/or substance dependency. By questioning the mental health professional, county attorney, defense counsel, and the person themselves, the board will obtain evidence to support a decision: (1) for release; (2) a commitment to a community based service which best meets safety and treatment

needs; or (3) commitment to an acute inpatient service either at a State Regional Center or hospital contracted with one of the six behavioral health regions.

Functioning as a neutral fact-finder in a legal court proceeding where civil justice is dispensed, board members have judicial immunity from potential liability.

Inpatient Commitment Orders and Warrants.

NRS Sec. 71-925 (4) provides in part:

If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

The foregoing was a change in the statutes enacted in July, 2004 and was enacted to eliminate orders that commit a subject to a specific regional center, which historically caused problems for both the subject and the regional centers. By virtue of 71-925 (4), if the board desires to commit a subject to inpatient treatment, the order must recite that the subject is placed in the custody of HHS.

Suggested Warrant of Inpatient Admission Form is located at (Appendix I or - www.hhss.ne.gov/beh/commit.htm).

Sec 71-931 requires every treatment order to include directions for the preparation and implementation of an individualized treatment plan. The treatment plan would include:

- (a) the nature of the subject's mental illness or substance dependence,
- (b) the least restrictive treatment alternative consistent with the diagnosis, and
- (c) intermediate and long-term goals for the subject and a projected timetable for the attainment of such goals.

The individualized treatment plan is to be filed with the board, as well as included in the subject's file and served on the county attorney, subject's file and served on the county

attorney, subject's counsel, and guardian, if any, within 5 working days after entry of the board's order. Treatment is to commence within two days after preparation of the plan.

Suggested individualized treatment plan form is located at (Appendix H or www.hhss.ne.gov/beh/commit.htm).

By the time the inpatient commitment order has been drafted, the mental health board should have already been in touch with HHS and Magellan to determine where appropriate placement in the HHS system lies. See 71-925(7). Although the commitment order itself does not specify commitment to a specific facility, law enforcement will be directed by the mental health board via the warrant to place the subject at a specific facility. Pertinent statutes relating to inpatient warrants may be found at 71-927, 71-928 and 71-929.

Synopsis of 71-927

When a subject is ordered to receive inpatient treatment and ordered to the custody of HHS, the Department has the duty to secure placement of the subject in appropriate inpatient treatment facility. The board then has the duty to issue a warrant authorizing the administrator of the specific treatment facility to receive and keep the subject as a patient.

Suggested Warrant of Inpatient Admission form is located at (Appendix I or www.hhss.ne.gov/beh/commit.htm).

The warrant shall state:

- the findings of the board
- the legal settlement of the subject, if known, or any available information
- the specific treatment facility to receive and keep the subject as a patient

According to 71-927, the warrant "shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the

Nebraska Mental Health Commitment Act...” (Appendix A or www.hhss.ne.gov/beh/commit.htm).

Synopsis of 71-928

When a subject is ordered to receive inpatient treatment, the findings of the mental health board and warrant shall be delivered to the sheriff or other suitable person appointed by the board to execute the warrant. Although the statutes do not delineate the term, “findings” could reasonably be interpreted to mean, among other things, a copy of the order of commitment.

Upon receipt of the warrant from the board, the sheriff (or other appointed person) has the responsibility of delivering the warrant, the findings and the subject to the treatment facility as designated on the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject.

71-928 provides that the sheriff (or other appointed person) may take with him/her such assistance as may be required to execute the warrant.

The administrator of the treatment facility has the responsibility to acknowledge the delivery of the warrant by signing the same. The administrator, in the acknowledgement of delivery, shall also record whether any person accompanied the subject and the name of such person. The sheriff has the duty to return the warrant to the clerk of the district court along with his/her costs.

Synopsis of 71-929

71-929(1) outlines the procedure if advance funds are needed to pay the sheriff or other suitable person for the admission or return of a subject to a treatment facility.

71-929(2) details what the sheriff shall include in his statement of expenses when he executes upon the warrant.

71-929(3) details how the sheriff shall be reimbursed for expenses incurred in conveying a subject to a treatment facility.

71-929(4) changed the MHCA in 2004 by specifically setting forth that the *county* is responsible for payment of transport costs associated with the admission or return of a subject to a treatment facility. Prior to the enactment of this section, the statutes were silent as to who was responsible for payment of such expenses to the sheriff (or other suitable person). The new language in the state provides:

“(4) All compensation and expenses provided for in this section shall be allowed and paid out of the treasury of the county by the county board”.

Outpatient Commitment Orders and Warrants.

71-925(6) authorizes outpatient commitment by the board. That statute dictates that the order of the board “shall represent the appropriate available treatment that imposes the least possible restraint upon the liberty of the subject...Inpatient hospitalization or custody shall be considered as a treatment of last resort.” As was previously discussed in regards to inpatient commitments, Sec. 71-931 also requires every outpatient treatment order to include directions for the preparation and implementation of an individualized treatment plan.

Suggested Outpatient Commitment Order Form is located at (Appendix J or www.hhss.ne.gov/beh/commit.htm).

Unlike the statutes pertaining to the placement of inpatient commitments (71-927 to 71-928), the law does not specify how the board is to secure placement of the subject following an order of commitment to an outpatient treatment facility.

Sec. 71-933 set forth a process to be followed in an outpatient setting that allows the board to intervene to protect the subject or others. The outpatient treatment provider has the duty to report to the board and the county attorney if:

- (a) the subject is not complying with the individualized treatment plan
- (b) the subject is not following conditions set by the board
- (c) the treatment plan is not effective
- (d) there has been a significant change in the subject's mental illness or substance dependence.

The county attorney has the duty to investigate the report. If the county attorney determines the report has no factual basis, no further action need be taken other than notifying the board. If the county attorney determines that there is a factual basis for the report and that intervention by the board is necessary to protect the subject or others, the county attorney may motion the matter back before the board for further hearing.

The county attorney has the option of applying for a warrant to take the subject into immediate custody pending hearing if the county attorney believes the subject poses a threat of danger to himself or others. The application for a warrant must be supported by an affidavit or sworn testimony of the county attorney or "any informed person".

71-933(2)(d). Sworn testimony may be taken telephonically at the discretion of the board.

71-934 states that the board may, on its own motion or through a motion filed by the county attorney, hold a hearing to determine whether an outpatient subject can be adequately and safely served by the individualized treatment plan on file. Pending hearing, the board may issue a warrant directing any law enforcement officer to take custody of the subject and to transport the subject to a treatment facility. No subject is to

be held for more than seven days unless the board grants a continuance. At the time of execution of the warrant, the subject is to be personally served with a motion and notice of hearing, along with a list of rights guaranteed to the subject under the Act. Following hearing, the board determines if outpatient treatment will be continued, modified or ended.

Review Hearings

71-935(1) provides that upon the filing of the periodic report, the subject is entitled to a hearing within 14 days of his request to seek an order of discharge or a change in treatment. The board also has the authority to schedule a review hearing:

- (a) at any time a treatment facility notifies the board of its intent to release the subject from its custody pursuant to 71-937 or at any time the board feels it necessary to determine whether the subject is adhering to the conditions of his release
- (b) upon request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the entity designated to oversee the subject's individualized treatment plan
- (c) upon the board's own motion

Such hearings have the same due process protections as are afforded in the commitment hearings. 71-935(2) the board has the authority at a review hearing to discharge the subject or enter a new treatment order.

Notice of Discharge

71-937 provides that the treatment facility is supposed to notify the board in writing of the release of the subject, which notice is to be immediately forwarded to the county attorney. Further:

“The mental health board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous and consequently not a proper subject for release. “

Post Release Conduct Hearings

71-938 provides for a hearing to “determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication.” The hearing may be held on the board’s own motion or upon a motion filed by the county attorney. A finding that the subject is mentally ill and dangerous by clear and convincing evidence mandates that the board enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.”

Escape from Treatment Facility

71-939 states that when a subject is absent without authorization from a treatment facility, the administrator shall immediately notify the Nebraska State Patrol and the court or clerk of the mental health board of the judicial district from which such person was committed.

The notice shall include:

- the person’s name
- a description of the subject
- a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others.

The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person.

Suggested Warrant of Inpatient Admission Form is located at (Appendix I or www.hhss.ne.gov/beh/commit.htm).

Any law enforcement officer may execute such warrant. Pending the issuance of the warrant, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization. Such person shall be returned to the treatment facility or shall be placed in facility for emergency protective custody as described in 71-919 until the subject can be returned to the treatment facility. **Suggest Warrant of Arrest Form** (Appendix G or www.hhss.ne.gov/beh/commit.htm).

Personal Rights of Subjects

Rights of a subject of a mental health board proceeding for commitment of a mentally ill and dangerous person.

A. Procedural rights

1. To written notice of the time and place of hearing.
2. To notice of the reasons alleged for believing the subject is a mentally ill and dangerous person who requires Mental Health Board Ordered treatment
3. To receive a copy of the petition.
4. To a list of his/her rights.
5. To the label of the mental disorder of the subject unless the physician or mental health professional on the board determines that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label.
6. To inquiry by the Board as to whether the subject has read and understood the petition and list of rights.
7. To a lawyer (Board appointed if the subject is indigent)
8. To access (either in person or through his/her attorney) all evidence and information including the label given to the alleged mental illness.
9. To an independent evaluation by physicians or clinical psychologists and to have their testimony and assistance in the subjects behalf. If the subject is indigent, the reasonable cost of the evaluation and related professional assistance in the subject's behalf will be paid by the Board.
10. To have continuances liberally granted.
11. To closed hearings unless the subject requests that they be open.
12. To be present at all hearings and present witnesses and information defending against the petition
13. To subpoena witnesses to testify for the subject's defense.
14. To confront and cross examine witnesses and evidence
15. To have rules of evidence applicable in civil proceedings apply to Board hearings.
16. To testify or refuse to testify.
17. To be free of such quantities of medication or other treatments prior to any Board hearing as would substantially impair his/her ability to assist in his/her defense at the hearing.
18. To written statements by the Mental Health Board about the evidence relied upon and the reasons for finding clear and convincing proof at the hearing that the subject is a mentally ill and dangerous person, that less restrictive alternatives are

not available or feasible to prevent the harm and for the choice of the particular treatment ordered.

19. To have the Board's written findings made part of the person's record.
20. To have all proceedings be of record
21. To appeal the decision of the Mental Health Board to the District Court and to appeal a final order of the District Court to the Court of Appeals

B. Rights while in custody or Board ordered treatment.

1. To be considered legally competent for all purposes (ie. Voting, contracts, use of money, marriage, divorce, etc.) unless one has been declared legally incompetent.
2. To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in one's treatment planning activities (to the extent deemed appropriate by the mental health professional responsible)
3. To refuse treatment medication, except (a) in an emergency, such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself or others or (b) following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.
4. To communicate freely with all persons by sealed mail, personal visitation or private telephone communications.
5. To have reasonably private living conditions, including private storage space for personal belongings.
6. To engage or refuse to engage in religious worship and political activity.
7. To be compensated for labor in accordance with the fair labor standards act.
8. To have access to a grievance procedure
9. To file writs of habeas corpus to challenge the legality of his or her custody or treatment.
10. To have his/her records remain confidential except as otherwise provided by law.
11. To have access to his/her records unless ordered otherwise by the Court.

Rights of a subject of a mental health board proceeding for commitment of a dangerous sex offender

A. Procedural rights

1. To written notice of the time and place of hearing.
2. To notice of the reasons alleged for believing the subject is a dangerous sex offender who requires Mental Health Board Ordered treatment
3. To receive a copy of the petition.
4. To a list of his/her rights.
5. To the label of the mental disorder of the subject unless the physician or mental health professional on the board determines that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's counsel rather than the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label.
6. To inquiry by the Board as to whether the subject has read and understood the petition and list of rights.
7. To a lawyer (Board appointed if the subject is indigent)

8. To access (either in person or through his/her attorney) all evidence and information including the label given to the alleged mental illness.
9. To an independent evaluation by physicians or clinical psychologists and to have their testimony and assistance in the subject's behalf. If the subject is indigent, the reasonable cost of the evaluation and related professional assistance in the subject's behalf will be paid by the Board.
10. To have continuances liberally granted.
11. To closed hearings unless the subject requests that they be open.
12. To be present at all hearings and present witnesses and information defending against the petition
13. To subpoena witnesses to testify for the subject's defense.
14. To confront and cross examine witnesses and evidence
15. To have rules of evidence applicable in civil proceedings apply to Board hearings.
16. To testify or refuse to testify.
17. To be free of such quantities of medication or other treatments prior to any Board hearing as would substantially impair his/her ability to assist in his/her defense at the hearing.
18. To written statements by the Mental Health Board about the evidence relied upon and the reasons for finding clear and convincing proof at the hearing that the subject is a dangerous sex offender and, that less restrictive alternatives are not available or feasible to prevent the harm and for the choice of the particular treatment ordered.
19. To have the Board's written findings made part of the person's record.
20. To have all proceedings be of record
21. To appeal the decision of the Mental Health Board to the District Court and to appeal a final order of the District Court to the Court of Appeals

B. Rights while in custody or Board ordered treatment.

1. To be considered legally competent for all purposes (ie. Voting, contracts, use of money, marriage, divorce, etc.) unless one has been declared legally incompetent.
2. To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in one's treatment planning activities (to the extent deemed appropriate by the mental health professional responsible)
3. To refuse treatment medication, except (a) in an emergency, such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself or others or (b) following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.
4. To communicate freely with all persons by sealed mail, personal visitation or private telephone communications.
5. To have reasonably private living conditions, including private storage space for personal belongings.
6. To engage or refuse to engage in religious worship and political activity.
7. To be compensated for labor in accordance with the fair labor standards act.
8. To have access to a grievance procedure
9. To file writs of habeas corpus to challenge the legality of his or her custody or treatment.
10. To have his/her records remain confidential except as otherwise provided by law.
11. To have access to his/her records unless ordered otherwise by the Court.

LB 1199 SUMMARY

LB 1199 (Bourne) Change provisions relating to sex offenders.

LB 1199 provides crimes and penalties regarding sexual assault of a child, provides civil commitment for sex offenders, provides for community supervision of sex offenders, changes provisions of the Sex Offender Registration Act, adopts the Sexual Predator Residency Restriction Act and establishes a working group to study sex offender treatment and management services.

CRIMES AND PENALTIES:

A person commits sexual assault of a child in the first degree if he or she subjects another person under 12 years old to sexual penetration and the actor is at least 19 years of age or older. Sexual assault of a child in the first degree is a Class IB felony with a mandatory minimum sentence of 15 years in prison for first offense. Any person who is found guilty of sexual assault of a child in the first degree under this section of law and who has prior convictions of sexual assault shall be guilty of a Class IB felony with a mandatory minimum sentence of 25 years in prison.

Sexual assault of a child is in the second degree if the actor causes serious personal injury to the victim. Sexual assault of a child in second degree is a Class II felony for the first offense. Any person found guilty of this offense and who has prior convictions of sexual assault shall be guilty of a Class IC felony and shall be sentenced to a mandatory minimum term of 25 years in prison.

Sexual assault of a child is in the third degree if the actor does not cause serious personal injury to the victim and is a Class IIIA felony for the first offense. Any person who is guilty of this offense and has prior sexual assault convictions shall be guilty of a Class IC felony.

Time limitations for prosecution or punishment will not apply to these sexual assault crimes.

CIVIL COMMITMENT:

LB 1199 provides a process for emergency protective custody of dangerous sex offenders. Such persons shall be admitted to an appropriate and available medical facility unless they have a prior sex offense conviction. If such persons have a prior sex offense conviction, they shall be admitted to a jail or Department of Corrections unless a medical or psychiatric emergency exists.

LB 1199 adopts the Sex Offender Commitment Act. The purpose of this act is to provide for the court-ordered treatment of sex offenders who completed their sentences, but continue to pose a threat of harm to others. It is the public policy of this state that dangerous sex offenders be encouraged to obtain voluntary treatment. This act provides for the civil commitment of dangerous sex offenders. The procedures such as filing of petition, mental health board hearings, treatment orders,

commitments, execution of warrant and rules of evidence mirror the current Mental Health Commitment Act. The language, Sex Offender Commitment Act, is incorporated into the current mental health commitment statutes.

At least 90 days prior to the release of a sex offender, the agency with jurisdiction over such individual shall notify the Attorney General, Nebraska State Patrol, prosecuting county attorney and the county attorney in which an individual is incarcerated, supervised or committed. Also, the Board of Parole shall notify these same parties within 5 days after scheduling a parole hearing. Further, a county attorney shall, no later than 45 days after receiving notice of the pending release of a sex offender, notify the Attorney General whether he/she intends to initiate civil commitment proceedings against such individual upon their release.

LB 1199 creates a separate legal standard for sex offenders. This standard defines dangerous sex offender as a person:

- who suffers from a mental illness which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of one or more sex offenses and who is substantially unable to control his/her criminal behavior or
- with a personality disorder which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of two or more sex offenses and who is substantially unable to control his/her criminal behavior.

This bill requires the Department of Corrections to order evaluations for offenders convicted of first degree sexual assault, repeat offenders, child predators who refuse treatment and offenders who have violated the Sex Offender Registration Act. This evaluation shall be ordered at least 180 days before the release of the individual. Upon completion of this evaluation, this department shall send written notice to the Attorney General, county attorney of the county where the offender is incarcerated and the prosecuting county attorney. An affidavit of the mental health professional shall be included in the notice.

COMMUNITY SUPERVISION:

LB 1199 provides for lifetime community supervision of sex offenders. Upon completion of his/her term of incarceration or release from civil commitment, the following classes of sex offenders will be supervised in the community by the Office of Parole Administration (Office) for the remainder of his/her life:

- Repeat sex offenders,
- offenders convicted of sexual assault of a child in the first degree or
- offenders convicted of penetration of a victim 12 years or more through the use of force or threat of serious violence or victim under the age of 12 years of age.

Lifetime community supervision applies to any of these individuals, on or after the effective date of this act.

The agency or political subdivision which has custody of such individuals shall notify the Office at least 60 days prior to release. Such individuals shall undergo a risk

assessment and evaluation by the Office. Conditions of community supervision imposed by the Office are provided.

Individuals that violate one or more of the conditions of community supervision shall undergo a review by the Office. The Office may revise or impose additional conditions, request prosecution by Attorney General or county attorney or recommend civil commitment. Criminal penalties are provided.

LB 1199 provides duties for parole officers. Also, this bill provides notification and supervision duties for the Office. Such individuals are entitled to an appeal whenever there is a determination or revision of conditions of community supervision. An appeal process is provided. In addition, notification requirements to such individuals are provided for the sentencing court.

Prior to the release of a person serving a sentence an offense requiring lifetime community supervision, the Department of Corrections, Department of Health and Human Services, or city or county correctional or jail facility shall provide written notice that he/she shall be subject to lifetime community supervision by the Office. This notice shall inform the person that he/she is subject to a lifetime community supervision, consequences of violations of conditions and right to challenge the determination of the conditions. Also, these agencies or county/city jails must require the defendant to read and sign a form stating they understand these conditions and retain a copy of the written notification.

SEX OFFENDER REGISTRATION ACT:

LB 1199 expands the list of offenses that require registration under this act. Specifically, the offenses of sexual assault of a child in second or third degree, sexual assault of a child in the first degree and debauching a minor are included. Also, any person who enters the state and is required to register as a sex offender under the laws of another state, territory, commonwealth or other U.S. jurisdiction must register in this state.

LB 1199 clarifies the reporting requirements of sex offenders under this act. Within 5 working days, persons under this act must notify, in writing, the sheriff of any changes in address, employment, vocation, school of attendance, temporary domicile, and name change.

LB 1199 provides additional requirements for courts and the Department of Corrections relating to informing the defendant that fingerprints and a photograph will be obtained by any registering entity in order to comply with the registration requirements.

Public notice provisions are expanded to allow disclosure of information of sex offenders under community supervision to the Office of Parole Administration. Also, information of sex offenders working at or attending a postsecondary educational institution must be disclosed to law enforcement or campus police.

This bill increases the penalty for second convictions for failing to comply this act. Also, persons who have violated this act and have been committed to the Department of Corrections are required to attend treatment and counseling programs.

SEXUAL PREDATOR RESIDENCY RESTRICTION ACT:

This bill allows a political subdivision to enact an ordinance, resolution, or other legal restriction prescribing where sex offenders may reside only if the restrictions are limited to sexual predators and extend no more than 500 feet from a school or child care facility. Exemptions for correctional institutions, treatment facilities and dates of establishing a residence are provided. Ordinances, resolutions or other legal restrictions are void if they do not meet the requirements of this act.

SEX OFENDER WORKING GROUP:

The Director of Regulation and Licensure shall establish a working group to study sex offender treatment and management services and recommend improvements. This working group shall include a member of the Legislature appointed by the Executive Board of the Legislative Council. The Governor shall appoint a representative from HHS, Corrections, Probation System, Board of Parole, law enforcement, courts, private providers of this treatment, and victim advocates. Also, the Governor shall appoint a licensed psychologist, licensed alcohol and drug counselor and sex offender participating in a treatment program. Other interested persons may be appointed in a nonvoting capacity as needed.

This working group shall study sex offender treatment and management on the state level to determine future legislative and executive actions. These actions shall be based on the recommendations of the 2001 Governor's Working Group on the Management and Treatment of Sex Offenders report involving credentialing of professionals providing this treatment, mandated treatment standards and increased training opportunities for these professionals.

The Director of Regulation and Licensure, in consulting with this working group, shall submit a report of this study to the Legislature and Governor by December 1, 2006. This working group terminates on December 1, 2006.

LB 1199 becomes effective July 14, 2006.

Precedent Setting Legal Cases

Three court cases setting legal precedent for mental health boards may have an impact on commitment decisions and should be noted: those of Olmstead, Wickwire, and Albert. These cases involve (1) the mandate for least restrictive placement; (2) the lack of jurisdiction over a person with mental retardation; and (3) the importance of obtaining the required training set by law for mental health board members.

The Olmstead v. L.C., 527 U.S. 581 (1999) case involved a person held in a Georgia mental institution who wanted community placement. Using the Americans with Disabilities Act as reference, the Supreme Court found that it is discriminatory to provide services in an institution when an individual could be served more appropriately in a community-based setting. It was argued that unjustified retention is a form of discrimination limiting exposure to the outside community; that a person's rights were violated when held in an inappropriate level of care. The ruling applies when treatment professionals determine community placement appropriate and transfer from institutional care to community setting is agreed to by the individual. Also, the placement must be reasonably accomplished by the state, taking into consideration the resources of the state and the needs of the mentally ill person.

Nebraska's decision In re Wickwire 259 Neb. 305, 609 NW2d 384 (Neb. 2000) concerned an individual with an IQ of 40, considered to be mentally retarded who did not have a diagnosis of mental illness. His developmental disability included serious behavioral issues and, due to his aggressive and violent behavior, the Lancaster County Attorney filed a mental health board petition stating that Wickwire was a mentally ill and dangerous person, recommending inpatient placement at the Lincoln Regional Center. However, psychiatrists at Lincoln Regional Center testified that treatment at a psychiatric hospital would not benefit Wickwire, due to his diagnosis of mental retardation, not

mental illness. The court ruled that although the mental health board found him a dangerous person, they had no jurisdiction over persons with mental retardation; and that the state of Nebraska did not intend the terms “mental illness” and “mental retardation” to be used interchangeably.

In another Nebraska District court case, from Platte County District court, (August 24, 2001), a mental health board decision was declared null and void because two of the three board members had not completed mental health board training as required by statute within the past two years as required by statute. Statute 71.916 still makes mental health trainings mandatory. Albert had served time in prison for first degree sexual assault. At the time of his release, a petition was filed under the Mental Health Commitment Act and he was committed to Norfolk Regional Center as a mentally ill and dangerous person. Albert brought a writ of habeas corpus, alleging that he was unlawfully imprisoned because the actions of the board were void, due to their not having followed the law requiring yearly training for board members. The court found for Albert and he was discharged.

New Law/Cases

1. The new Mental Health Commitment Act, NRS Sec. 71-901 et seq., became effective July 1, 2004. There were two changes in the MHCA that became effective July 1, 2005.
 - (i.) **NRS Sec. 71-906.** The legislature expanded the definition of “mental health professional” to include an advanced practice registered nurse who has certification in a mental health specialty, as well as a person licensed to practice medicine and surgery or psychology.
 - (ii.) **NRS Sec. 71-922.** The legislature mandated that board proceedings are deemed to have commenced upon the earlier of (a) the filing of a petition or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody or the administrator of the treatment center having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.

2. **In re Interest of E.M.** 13 Neb. App. 287 (2005) examined 83-1045.02, which provides that “no person may be held in custody pending the hearing for a period

exceeding seven days, except upon a continuance granted by the board.” The language remains essentially the same in the new MHCA at 71-934, which provides “no person may be held in custody under this section for more than seven days except upon a continuance granted by the board”.

The subject in E.M. was taken into custody on September 17, 2003 and the hearing was held on September 25. The subject argued that he was denied his statutory right to a hearing within 7 days of being taken into custody.

Held: “The ‘seven days’ language of Section 83-1045.02 is directory, not mandatory, and that even assuming the provision was violated in this case, violation of the provision does not mandate dismissal of the proceedings.” 13 Neb. App. 287 (2005) at 294.

3. In re Interest of Verle O., 13 Neb. App. 256 (2005). In 1993, Verle entered a plea of “no contest” to attempted first-degree sexual assault on a child in a criminal case and was incarcerated. Nine years later, at the time the Verle was to be discharged from the department of corrections, the state filed a petition with the mental health board alleging Verle was mentally ill and dangerous. Under Section 83-1009 [re-codified at 71-908], there must be a recent violent act, a threat of violence, or an act placing others in reasonable fear in order to find that a person is dangerous. The Board found Verle to be mentally ill and dangerous, but failed to specify any specific recent violent act or threat of violence that would make Verle dangerous as required by statute. Instead, the board relied on the no contest plea and statements made on the record by Verle at that plea hearing as the factual basis for finding Verle mentally ill and dangerous.

Held: By entering a plea of no contest (as opposed to entering a guilty plea), Verle avoided making any admissions of fact; therefore, any statements made by Verle in connection with the no contest plea were not admissible as evidence in the civil commitment proceeding. The mere fact that Verle plead no contest to an attempted assault does not in and of itself establish that Verle performed recent violent acts as required by statute. Additional facts must be established to sustain a commitment.

Board Determination of Mental Illness

1. Overview of Mental Illness

The first determination a mental health board must make is whether a person is mentally ill, alcoholic, or drug abusing. In the scope of the commitment process, “mentally ill” is considered to include alcoholics and drug abusers. Mental illness is not defined in the Act. A psychiatrist, a licensed clinical psychologist or a APRN is allowed by law to diagnose mental illness and will present an evaluation of the person appearing before the board. By statute a licensed alcohol and drug abuse counselor (LADAC) can diagnose substance dependency and other substance abuse issues. If board members have

questions about the reported diagnosis, symptoms, or behaviors of a person appearing before them, it is important to question the mental health professional or LADAC and to receive answers.

Clinicians use the latest edition of DSM, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as the standard for diagnostic criteria in determining mental illness. There are five Axis categories in a diagnosis:

Axis I -- Mental Illness, and or substance abuse or
..dependence

Axis II -- Personality disorders, mental retardation

Axis III -- Physical conditions and disorders

Axis IV -- Psycho-social and environmental problems, stresses
(housing, support group, occupation, education, social, legal
system problems, accessing health care)

Axis V -- GAF (Global Assessment of Functioning; the rate of
current overall occupational, psychological and social
functioning expressed as a single number on a 1 to
100 point scale) Low to Normal = 75-100.

Mental illness can be viewed as a collection of symptoms, either behavioral or psychological, which cause an individual distress, disability, or an increased risk of suffering, pain, disability, death, or loss of freedom. Mental illness can be a thinking disorder such as schizophrenia with its characteristic delusions and hallucinations; or a mood disorder with depression; anxiety, panic disorder; a bipolar disorder which may have cycles of depression and mania; behavior disorders; personality disorders; or alcohol and drug dependence disorders.

A mental status examination is an evaluation of a person's current mental functioning, which aids a clinician in arriving at a diagnosis. A typical mental status exam (MSE) covers the following areas:

- Appearance and Behavior: dress, grooming, posture, physical characteristics, facial expression, eye contact, motor activity, cooperation
- Speech: rate, loudness, amount, clarity
- Emotions: mood—depressed, anxious, euphoric, angry
- Thought: Suicidal or homicidal ideation, logic, flow of ideas, content, delusions, preoccupations or obsessions, phobias
- Perception: presence of auditory, visual, tactile, olfactory hallucinations
- Insight and Judgment: orientation to time, place, person, concentration, memory, fund of knowledge, judgment, insight or awareness of mental illness, intelligence

2. *Overview of Substance Abuse versus Substance Dependence*

Substance abuse or substance dependency are terms often heard when a board listens to testimony at a hearing. It is necessary to differentiate between abuse and dependency. *Substance addiction, substance dependence and chemical dependency* refer to an **addiction**, while *substance **abuse*** is *temporary use of alcohol or other drugs which cause problems in a small part of an individual's life*. Abusers are able to recognize the relationship between their alcohol and/or drug use, the problems it causes and can stop their abuse with a little help and encouragement.

In dependence, use of the substance becomes progressively worse. A diagnosis of dependency includes meeting the criteria of increased tolerance, withdrawal symptoms, and a pattern of compulsive use. Persons who are dependent continue using substances in spite of increasingly severe consequences in personal and social lives and physical health.

Common symptoms of dependency are: 1) increasing episodes of intoxication; 2) loss of interest in other pursuits; 3) loss of control over usage; 4) repeated remorse over the results of substance use; 5) increased tolerance to the drug (including alcohol); 6) negative reactions to withdrawal from the drug (Best direct evidence of alcoholism is the

appearance of withdrawal symptoms one to two days after last drinking alcohol); 7) memory failures as a result of use; 8) serious personal and social consequences resulting from substance use such as problems with relationships, work, or with the law.

Intoxication by itself doesn't indicate dependency. However when episodes of intoxication occur with increasing frequency, involving larger amounts of a substance due to tolerance, resulting in increasingly severe personal and social consequences over an extended period of time--a diagnosis of dependency is almost certain. Other indicators for alcohol dependence are:

- Drinking at or before breakfast
- Drinking non-beverage forms of alcohol (Rubbing alcohol, cologne, etc.)
- Traffic difficulties (DUI, DWI arrests)
- Problems at work related to alcohol use
- Relationship problems related to usage; fighting associated with drinking
- Inability to stop drinking even if the person has wanted to
- Drinking binges
- Black outs (a person has no memory of his behavior or events although during that time he appeared conscious and aware)

3. Overview of "Dual Disorders & Dual Disorder Treatment"

As more and more persons present with multiple problems and illnesses in the commitment process, there is an increasing need to understand the differences between dual disorders, dual disorder treatment and dual enhanced treatment for co-occurring disorders. Understanding the differences between these levels of duality will help the Mental Health Board be able to make appropriate decisions for the least restrictive placement of a person depending upon the severity of the dual issues presented.

A **dual disorder** occurs when an adult has a primary Axis I severe and persistent mental illness (SPMI) diagnosis and a primary Axis I substance dependency diagnosis. It

is important to remember that there are only a few mental illnesses that are included within the category of **severe and persistent mental illnesses**: schizophrenia or schizoaffective disorder, bipolar disorder, major depression, and other psychotic disorders. It is also important to know that substance dependency is much more severe and chronic than substance abuse. **Dependency** is a pattern of repeated substance use that results in tolerance, withdrawal, and compulsive substance-taking behavior, where substance abuse does not include these characteristics. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. In combination, these two diagnoses (SPMI/SD) present unique problems for Mental Health Boards in determining the least restrictive treatment placement while ensuring public safety.

There are only a few persons that meet this severe level of dual disorder. The Mental Health Board should carefully determine if the subject in the hearing has this level of severity to be considered dually diagnosed. Dual disorder clients eligible for **dual disorder treatment** will exhibit more unstable or disabling levels of SPMI and dependency. The typical client is disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in simultaneous addiction treatment. It is also important to determine if the acute symptoms are stabilized or, if the subject needs further stabilization before being able to benefit from a dual treatment program. The subject must not display symptoms of intoxication and must be stable on psychotropic medication(s) in order to be admitted to a community based dual treatment program. Often a short stay at an acute inpatient program for psychiatric stabilization, and then a move to a community based dual disorder residential treatment program provides the most appropriate primary integrated treatment to address both the mental illness and the substance dependency problems simultaneously.

When a person with a mental illness such as schizophrenia acquires a substance dependency, serious consequences result. There can be more severe impairments while using lesser quantities, less frequently. There is a higher risk of non-compliance with mental health treatment, in fact, they are eight times more likely to be non-compliant with medications. Psychiatric symptoms fluctuate more rapidly and are more severe. In addition, there are increased mood swings, more psychiatric re-hospitalizations, violent acting out behavior, suicidal ideation, and suicide attempts. If a person with substance dependency has established an entrenched pattern of chronic use, hallucinations, manic behavior, suicide ideation and delusional behavior can occur resulting from the habitual use of substances.

A person with a dual disorder requires specific psychiatric and mental health support and monitoring in order to participate in treatment for alcohol and/or drug addiction. Due to the multiple problems, they need an individualized and flexible approach to treatment. The supportive, non-threatening approach is more therapeutic for a dually diagnosed person whereas a confrontive approach would be difficult to tolerate, especially if symptoms of paranoia are present.

4. “Overview of Co-Occurring Disorders & Dual Enhanced Treatment”

An increasingly common diagnosis is when the subject has a primary mental illness and a secondary substance use or abuse disorder, OR a primary substance abuse disorder and a secondary mental illness. These combinations of dual issues are termed **Co-occurring disorders** and are appropriate for **dual enhanced treatment**. Dual enhanced treatment is for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers(mental health or substance abuse) of these treatment services may elect to “enhance” their primary service to address the client’s other relatively stable diagnostic or sub-diagnostic co-occurring disorder. The primary

focus of such programs is either mental health OR abuse/dependency treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

Alcohol is the substance most frequently used by persons with mental illnesses, followed by cocaine, marijuana and methamphetamine. About 50% of persons in a psychiatric clinical setting will have a substance disorder. The lifetime prevalence of a substance disorder in persons with schizophrenia is 47%; in those with bipolar disorder, it is 56%; and in those with major depression, it is 27%. Research studies show that 29% of people with an Axis I psychiatric disorder will have a substance abuse disorder at some time in their lives. Persons with mental illness report similar reasons as the general population for using substances: attempting to improve unpleasant moods such as anxiety and depressions, increasing social interaction, and increasing pleasure by feeling “high”. While mentally ill persons may use substances in order to deal with symptoms, people without mental illness can display psychotic symptoms due to substance use, such as anxiety, panic, mood swings, hallucinations, delusions, amnesia, personality changes, insomnia, and eating-disordered behavior. Both dependence and psychosis feature loss of control of behavior and emotions, and in both instances symptoms respond to treatment.

It is difficult for strictly substance abuse treatment agencies to serve a dually disordered person in their population just as it is difficult for strictly mental health treatment agencies to serve the dually diagnosed person. It is important to note that Nebraska’s Regional Centers provide dual enhanced treatment for co-occurring disorders only. They do not have integrated dual disorder treatment programs nor are they equipped to served the dually diagnosed client. The specific mission of the Regional Centers in Nebraska is to provide acute inpatient and secure residential mental health services. While they have a few licensed alcohol and drug abuse counselors on staff to do dual enhanced programming, treating substance dependency and substance abuse is not a role

for the Regional Center. The expertise in substance treatment in Nebraska is in community based programs.

Board Determination of Dangerousness

1. Magnitude, Likelihood, Imminence and Frequency

The second decision at a commitment hearing is determining whether a person is dangerous—not only whether dangerousness *is present*, but also *to what extent* risk of violence or dangerousness toward self or others exists. Areas of dangerousness include: Suicide threat (verbal), suicide attempt, homicide threat (verbal), homicide attempt, threats to physically harm others, (verbal or nonverbal), destruction of property, and inability to provide the basic needs of food, clothing, shelter, safety, and medical care.

Dangerousness risk is a complex interaction of four factors of **Magnitude, Likelihood, Imminence, and Frequency (MLIF)**. Considering each of these factors can help assess the potential for violence.

* **Magnitude** of danger concerns the level of danger presented. For example, threats to harm people would be considered more dangerous than threats to harm property; threats of physical harm to others would be more serious than psychological threats. The use of a weapon escalates the risk of danger, of course, but the choice of weapon must be taken into consideration. The harm posed by a gun would be greater than that posed by a knife because a gun is five times more likely to cause death than a knife.

* **Likelihood** of dangerousness is the probability of occurrence of violence. While the best predictor of violence is past history of violence, research has shown that there are eight demographic elements which correlate statistically with an increased risk of violence:

1. Age: Violence peaks in the late teens and early 20's
2. Gender: Males are more violent than females. However, among the SPMI mentally ill population (Severely and Persistently Mentally Ill), the ratio of violent and aggressive acts is the same for males and females
3. Social Class: Lower socio-economic class members experience more street violence
4. IQ: Individuals with lower IQ's demonstrate more violence which may be related to an inability to talk out concerns or articulate needs
5. Education: Lower levels of educational achievement are associated with more violence
6. Employment: Risk of violence increases with job instability
7. Residence: Risk of violence increases with frequent changes of residence
8. Substance abuse: *Use of marijuana, alcohol, and other drugs increases the risk of violent behavior three-fold*; especially use of stimulants such as methamphetamine which reduce inhibitions and increase paranoia

* **Imminence** of danger, how soon the danger might occur, is contained in the statute's description as "near future." Each mental health board should have a working consensus of the definition of imminent—whether it is defined as right now, or within twenty-four hours, the most commonly used time frame. Having this time definition set before being placed under pressure to make a decision regarding a commitment is helpful. The sooner violence may occur, the greater the risk of danger due to not having a chance to mitigate circumstances or provide protection.

* **Frequency** is a factor when considering risks of dangerousness. Future violence is best predicted by past violence, as mentioned in likelihood of violence. The frequency of occurrence is a clear indicator that a pattern has been set and may be reoccurring.

2. *Risk Factors*

Risk factors can be static or dynamic. Some risks can be changed, for example, by taking away a weapon or the availability of a weapon. Another example could be when

psychosis is altered by enforcing oral medication compliance or by prescribing anti-psychotic medication delivered by injection, which can last from 2 to 4 weeks. The presence of a mental illness may be static, but the risks and deficits engendered by that condition may fluctuate.

It is important to note that the majority of the mentally ill population is not violent and dangerous, anymore than the majority of the general population. In fact, the percentage of overall violence in society attributed to those with mental illness or substance dependency is only **3%**. However, the likelihood of violence increases if a person's illness is active and in an acute stage. This is especially true if the illness is acute and psychotic. *Delusions* are more dangerous than hallucinations, especially when they are well organized, specific, and persecutory, i.e. "Blue-eyed people are really aliens who are out to get me." *Hallucinations* present a higher risk of violence if they are command auditory hallucinations, voices which command an individual to obey. If the command voice is familiar, like that of a parent, the person is more likely to obey the command. The most dangerous situation occurs when delusions are related to command hallucinations, with the delusions causing the hallucinations to make sense to the person, i.e., "Aliens are trying to take over the earth by replacing people with robots. My wife has been replaced with a robot. My deceased mother's voice whispers to me the only way I can get my wife back is to kill the robot imposter."

There are also risks from other forms of mental illness. While paranoid schizophrenia in an acute stage is more dangerous due to delusions and hallucinations, depression carries with it the risk of suicide. Those with manic mood symptoms may make more threats but cause less harm. People with personality disorders, especially those diagnosed with antisocial personality disorder who have no remorse for their behavior, and those who are impulsive, unable to accept redirection, pose a greater risk for violence.

Risk can also be assessed according to the potential for severity and occurrence, as delineated by the LOCUS parameters developed in 1997 by the American Association of Community Psychiatrists. The **Level Of Care Utilization System** rates potential for harm to self or others from minimal potential to extreme potential. An example of the rating system follows.

- Low potential for dangerousness: no indication of suicidal or homicidal thoughts or impulses; no history of suicidal or homicidal ideation; no indication of distress
- Moderate potential for dangerous behavior: significant current suicidal or homicidal ideation without intent or conscious plan and without past history; current distress may be present without active ideation, but a history of suicidal/homicidal behavior exists; past binge use of substances resulting in lack of inhibition and aggression towards others or self without recent episodes of such behavior; some evidence of self-neglect and compromise in ability to care for self
- Extreme potential for dangerous behaviors: current suicidal or homicidal behavior or intentions with a plan and means to carry out the plan; with a history of serious past attempts; or presence of command hallucinations or delusions which threaten to override impulse control; repeated episodes of violence toward self or others, or other behaviors resulting in likely harm to self or others while under the influence of alcohol or drugs; extreme inability to care for self or monitor the environment with deterioration in physical condition or injury related to these deficits.

Low potential correlates with consequences unlikely to result in harm, injury, property destruction, or no life threatening incidences. Even if imminent, the magnitude of danger

would be lower. Moderate potential would present greater magnitude, not as imminent, with consequences likely to result in harm, injury, or property destruction but without life threatening consequences. Extreme potential for dangerous behaviors is an acute level—high magnitude, imminent risk with consequences likely to include loss of life, limb, and/or major property destruction.

3. Spectrum of Aggressive Behavior

Aggressive behavior also falls along a spectrum--from verbal threats to severe injury. The following list of behaviors ranges from mild at number (a) to serious danger at number (d).

VERBAL AGGRESSION

- (a) Makes loud noises, shouts angrily;
- (b) Yells mild personal insults, e.g. "You're stupid!";
- (c) Curses viciously, uses foul language in anger, makes moderate threats to others or self; or
- (d) Makes clear threats of violence toward others or self, i.e. "I'm going to kill you!" or requests help to control self.

PHYSICAL AGGRESSION AGAINST OBJECTS

- (a) Slams door, scatters clothing, makes a mess;
- (b) Throws objects down, kicks furniture without breaking it, marks the wall;
- (c) Breaks objects, smashes windows; or
- (d) Sets fires, throws objects dangerously.

PHYSICAL AGGRESSION AGAINST SELF

- (a) Hits or scratches skin, hits self on arms or body, pinches self, pulls hair (with no or minor injury);
- (b) Bangs head, hits fist into object, throws self onto floor or into objects (hurts self without serious injury);
- (c) Small cuts or bruises, minor burns; or
- (d) Mutilates self, makes deep cuts, bites that bleed, internal injury, fractures, loss of consciousness, loss of teeth.

PHYSICAL AGGRESSION AGAINST OTHERS

- (a) Makes threatening gestures, swings at people, grabs at clothes;
- (b) Strikes, kicks, pushes, pulls hair (without injury);
- (c) Attacks others causing mild/moderate physical injury (bruises, sprains, welts); or
- (d) Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury).

4. *Danger to Self: Suicide*

An additional type of dangerousness a mental health board must determine is that of danger to self. When discussing the risks of dangerousness to self and suicide, several terms need to be defined:

- *Suicidal Ideation*—thoughts of ending one's own life
 Passive Ideation—thoughts without a plan
 Active Ideation—thoughts accompanied by a plan
- *Suicidal gesture*—self-inflicted harm done without a realistic expectation of death; possibly an attention-getting plea
- *Suicide attempt*—self-inflicted harm with clear expectation of death

Statistics from the year 2000 indicate that suicide is attempted 1,000,000 (one million) times a year. Of those attempted suicides, 1 in 18 is completed, with an annual death rate of 31,000.

One third of the population will have suicidal thoughts in their lifetime. Any threat, gesture, or act related to suicide needs to be taken seriously. The belief that a person who talks about suicide will not attempt it, is a fallacy.

The aim of suicide is not always death—it can be a cry for help, an attempt to reunite with a deceased loved one, or an escape from a life which has become intolerable due to depression, illness, or circumstances. Another underlying goal may be revenge; the belief that those left behind will suffer for their negative treatment of the person. The risk of a completed suicide is increased by depression, substance use, and disorganized thinking like that characteristic of schizophrenia.

A scale for evaluating the danger risk for suicidal patients was developed by Patterson, called the SADPERSONS scale.

S = Sex: Women make more attempts than men; however, due to men's choice of method, their attempts are more often fatal (gun versus pills)

A = Age: risk is greater for persons under 19 and over 45

D = Depression: greatly increases risk of suicide

P = Previous attempt: either by the person, or a family member (which makes suicide seem an acceptable choice when stressed)

E = Ethanol: alcohol use increases risk due to decreased judgment and increased impulsivity

R = Rational thinking: presence of impaired judgment

S = Social support: lack of meaningful, supportive relationships

O = Organized plan: the more organized the plan, greater the risk

N = No spouse: unmarried, divorced, widowed, separated people are at greater risk

S = Sickness: chronic debilitating conditions, pain

A signed contract for safety or no self-harm may decrease imminence of suicide and insure the possibility a person will not hurt himself at this time, but it is not a safeguard. Clients have willingly signed such a contract in order to avoid being taken into Emergency Protective Custody, or to get out of the mental health professional's office in order to make their planned attempt. There are several danger signs often found in the conversation of people who eventually attempt suicide. They include statements about hopelessness, helplessness, worthlessness, preoccupation with death and talk about suicide. Behaviors noted before suicide attempts were: losing interest in things previously cared about, setting affairs in order, and giving away prized possessions. Often people appeared suddenly happier, calmer, right before the attempt as though a decision had been made.

As with violence, the best predictor of suicide is history of previous attempts; or having a family member or close friend who completed suicide. The four factors of **Magnitude, Likelihood, Imminence** and **Frequency** can be applied to determining the risk of suicide as well. Information regarding the magnitude of harm, the proposed means of suicide, whether there is a family history of suicide the, and a history of previous attempts, is helpful in determining level of risk.

5. Danger to Self: Self-neglect

Suicide is not the only danger to self that a mental health board may encounter. Dangerous self-neglect includes risks due to inability to provide for the basic human needs of food, clothing, shelter, safety, and medical care. Inability to care for self may result from mental illness or alcohol or drug use. Impairment in activities of daily living include appearance and hygiene falling below acceptable standards, disturbance in sleep or eating patterns, homelessness, or putting self in harm's way, such as walking down the middle of a highway.

Self-endangering behaviors may be evident in the life of an alcohol or a drug-dependent persons; for example, drinking or drug use which compounds medical problems yet the person doesn't stop substance use despite deterioration in physical health. An alcohol dependant person on a binge or a methamphetamine user may not eat for days. Frequently alcohol dependant persons can become depressed and express thoughts of suicide or wanting to die while intoxicated. Addicts may seriously deplete family resources to the point that money is gone---leaving them and their families without resources for procuring food, shelter, clothing or medical needs. A substance dependent person may endanger not only his or her own life, but also the lives of others when driving while intoxicated or under the influence of drugs.

Information Required to Determine Commitment

If not enough information about the four risk factors for dangerousness is presented to the board, members have a duty to discover any elements related to dangerousness by questioning the individual before them, the mental health professional, and any legal representatives. Questions about (1) the precipitating event that brought about the petition for a hearing, (2) the person's behavior and (3) past history will aid in determining dangerousness. A label of "dangerous" or "violent" applied to a person should not be

accepted at face value, but must rest on a report of the incident and behavior. These facts must always be ascertained:

1. **WHAT:** The events, the person's behavior, diagnosis, presence or absence of mental illness or substance use
2. **WHO:** Identity of the victim(s). Research has shown that the mentally ill are most likely to commit violence on family members; if the victim is a stranger there is a higher risk
3. **WHEN:** Date, time, and importantly—frequency
4. **WHERE:** Circumstances as well as place
5. **WHY:** Attempt to determine what triggered the violence; was it in retaliation for an imagined or real event; what was the motivation behind the behavior (Note that a predatory or cold and calculated violent act is more often lethal than one arising from an emotional trigger of the moment)
6. **HOW:** Determine if there is a pattern by inquiring about past behavior, as discovering a pattern helps make a prediction

Research can't predict violence, but it has found elements statistically related to likelihood of violence. Answers to the following questions may help a mental health board in determining risk.

1. MENTAL STATUS: Was the person psychotic or intoxicated?
2. MOTIVATION: Was this a predatory or calculated and planned act, or was the affective acting out from emotional impulse?
3. EMOTION: What were the person's feelings before, during and after the event? Does the person express remorse for the act? (Fear and anger are most commonly associated with violent or aggressive acts; lack of remorse or lack of empathy for the victim is more dangerous)
4. IMPULSE: Has the person demonstrated unpredictable and impulsive behavior in the past? Over-controlled behavior? (Over-controlled behavior can also result in danger when long repressed emotions erupt suddenly, triggered by the proverbial "straw that broke the camel's back".)
5. VICTIM(S): Was the victim familiar and known or was the act perpetrated against a stranger?
6. WEAPONS: Related to the element of magnitude—was a weapon used? What weapon and what magnitude of harm either resulted or could have resulted? For example, was a plate thrown at the wall in anger or was a gun used?

7. **STRESSORS:** What were the biological or medical stressors affecting the person? Were there increased psychological or social stressors affecting their lives such as a lost job, broken relationship, recently diagnosed medical condition? (These would be listed on Axis IV of the DSM diagnosis)

Questions for MH Board Members to Ask at Hearings

The following list of questions would assist in gaining the insight required in order to select the most appropriate treatment option when making a commitment decision.

1. Questions to Ask Mental Health Professional or Licensed Alcohol and Drug Abuse Counselor (LADAC):

1. Is the client a danger to self or others?
2. What levels of care have you considered?
3. What is the least restrictive level of care that this client could be safely as well as effectively be treated?
4. What barriers are there to treating this client in the community? (lack of support system, inadequate transportation, etc.) Note that agencies which offer Community Support, both Mental Health and Substance Abuse/Dependence, provide transportation for clients as part of the service
5. What, if any, successful treatment history has this client had?
6. What tools were used in assessing this client? (face to face interview, record review, psychological testing, medical consult, family interview)
7. Was this client in a mental health or substance abuse/dependence service at the time they were placed under an EPC?
8. What is the diagnosis of the client? Does the client have a mental health diagnosis as well as substance abuse/dependence diagnosis? Are there any medical conditions that can worsen the mental health or substance abuse/dependence diagnosis? (Note: a diagnosis of dependency not abuse is required to commit a client to substance dependency treatment.)
9. Is this client medically and psychiatrically stable enough to participate in primary substance abuse treatment? (administer their own medications, perform activities of daily living, free from aggression)
10. If residential treatment is not recommended, is there a crisis plan for this client?

11. Are all the mental health providers involved in the assessment of this client in agreement regarding the current treatment recommendations?
12. What arrangements have been made for the treatment and commitment recommended for this client? (outpatient appointments, AA group location, transportation arrangements)

2. Questions to Ask Subjects:

1. Do you understand the recommended treatment plan?
2. What is your current diagnosis?
3. What medications are you taking and why do you take them?
4. Do you believe you can comply with the recommended treatment plan?
5. What would prevent you from succeeding in this treatment?
6. What current treatment are you receiving and with whom?
7. When was the last time you saw a mental health provider and who was it?

The Commitment Decision

71-925 (6)

(6) A treatment order by the mental health board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment programs or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

It is the board's responsibility to decide where a person's interest would be best served. Clearly, according to the statute, inpatient hospitalization is the treatment modality to be considered **LAST**. Board members should familiarize themselves with mental health and substance dependency services available in the state of Nebraska and the agencies providing those services in their region. When criteria for dangerousness are not met, then the board can then determine which type of community based outpatient commitment would provide the necessary treatment in a less restrictive environment, while also ensuring public safety.

An appearance before a mental health board and subsequent committal can be a life-changing event, not always for the better. Along with the emotional trauma and disruption, there is always risk associated with hospitalization including hospital-acquired infections, and physical danger from peers whose symptoms are more acute and less well controlled. The rationale for use of least restrictive placement is based on research showing patient outcome is more positive in a less restrictive setting. Good treatment at the appropriate level of care is also cost effective; it prevents the need to treat a person again and again, and it prevents costly over-treatment at an unnecessary level of care.

In the case of substance dependency, for example, a high need for treatment can be accommodated by outpatient/community based commitment to a short-term residential substance abuse program. If short-term residential services are not available another alternative for community substance dependency treatment is commitment to an IOP (Intensive Outpatient) substance dependency program, and substance dependency community support.

The Board's Responsibility in Reassessing Level of Care Decisions

When a commitment has been made, a mental health board has the option of re-evaluating a level of care decision.

If a person is not cooperating, not following conditions of release or not following an outpatient treatment plan, which may include their not taking the prescribed medication, then the treating mental health professional can inform either the board or the county attorney and a new hearing may be held.

Re-assessment of a level of care decision may also be necessary when a committed person, while waiting for an opening at an inpatient level of care center or residential substance abuse program, has been receiving treatment at a crisis center/hospital. If the board finds that (1) the person could no longer be considered mentally ill and dangerous; or (2) no longer substance dependent and dangerous; or (3) that no cause exists for care or treatment; or (4) that a less restrictive alternative exists--the board may order immediate discharge or change the treatment disposition per Neb. Rev. Stat. 71-935

Neb. Rev. Stat. 71-937 removes the language requiring seven days notice in advance of a release by a treatment facility.

Behavioral Health Reform in Community Based Services

Mental Health Board members must look at least restrictive levels of care, which meet the behavioral health needs of the person. New and expanded community based services are being developed as a part of behavioral health reform to better meet the needs of persons who are mentally ill *and* dangerous.

Outpatient commitments should be considered in most cases, as they are less restrictive and less traumatic to the person. Outpatient services include **residential services**. Outpatient Commitments may be made to the following community based services in Mental Health:

Psychiatric Residential Rehabilitation, Day Treatment, Community Support, Day Rehabilitation, Outpatient Therapy, and Medication Management. Commitment *may be made to more than one service, if needed, such as community support and medication management.*

Outpatient Commitments may be made to the following community based services in Substance Dependency:

Short Term Residential, Therapeutic Community, Halfway House, Partial Care, Intensive Outpatient, Community Support, and Outpatient Therapy. Commitment *may be made to more than one service, if needed, such as community support and outpatient therapy.*

The Mental Health Board may commit the person to Outpatient – directly to a provider of one of the above-mentioned services or, under the new legislation, to HHS for Inpatient (Acute or SubAcute) which will be provided through the Behavioral Health Regions by contracts with providers of Acute/SubAcute care. The Crisis Center would contact Providers of Inpatient (Acute and SubAcute care) and these services would be pre-authorized through Magellan Behavioral Health, the contracted provider of (ASO) Administrative Services Only. A list of providers of Acute and SubAcute care is available from the Division of Behavioral Health, P.O. Box 98925, Lincoln, NE 68509-8925.

As a result of the passage of LB1083, Mental Health Boards are to commit mentally ill and dangerous persons to Nebraska Health and Human Services for inpatient (Acute and SubAcute) care. HHS, through the community hospitals, and the state six behavioral health regions and the state

hospital, will provide the level of care necessary as determined by the mental health board upon reviewing the Professional Affidavit, testimony, and other pertinent information presented at the Mental Health Board hearing. A list of providers of mental health and substance abuse services in each region is available at the following address:

Division of Behavioral Health Services
P.O. Box 98925
Lincoln, NE 68509-8925.

As a part of LB1083, changes were made in training requirements for Mental Health Board Members. Under the new legislation, Mental Health Board Members must be trained **prior to serving on the Board**. Another change is that members must satisfactorily complete Mental Health Board Training at least once every four years.

Conclusion

The mental health commitment process involves three decisions. First, a determination must be made whether a person is mentally ill and/or substance dependent. The second decision in the process to commit or discharge is assessing for risk of dangerousness to self or others. Using the four factors of magnitude, likelihood, imminence, and frequency, a determination can be reached more readily. Finally, if a committal is deemed necessary, by law placement must be to the least restrictive level of care which would successfully treat the mental illness/substance dependence and prevent harm to self or others.

Mental health board members serve as part of a system of checks and balances, guarding an individual's personal rights while ensuring due process and protecting public safety. The board obtains information through questioning those at the hearing, the mental

health/substance abuse professionals, legal representatives and most importantly the person appearing before them. Based on that evidence, an objective decision can be made whether *clear and convincing evidence* has been presented that a *substantial risk of serious harm* exists within the *near future*.

The Mental Health Commitment Act was not created to punish behavior caused by mental illness. Rather, by mandating treatment for those either unable or unwilling to seek treatment on their own, due to mental condition or diagnosis, the Act protects their safety, the safety of society, and provides an individual with treatment which can lead to an improved quality of life.

Forced Medication

Section 71-959(3) provides that a subject has a right to refuse medication except “following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness.”

The foregoing provision, enacted in 2004, simply brought Nebraska’s statutes in line with U.S. Constitutional requirements as articulated by the U.S. Supreme Court in Mills v. Rogers, 457 U.S. 291 (1982) and Washington v. Harper, 494 U.S. 210 (1990). The Mills case involved the rights of an individual committed to treatment through a civil process similar to the Nebraska Mental Health Commitment Act. These two cases stand for the proposition that it is unconstitutional in our country to medicate someone against their will, without first providing them with a Due Process hearing on the issue of forced medication.

This proposition was more recently articulated in Sell v. U.S., 539 U.S. 166 (2003), a criminal case in which the defendant was found to be not competent to stand trial and a danger to himself and others. Mr. Sell refused to take medication to make him competent to stand trial on felony charges. The Court held that under the Constitution, the government may administer drugs to render an individual competent to stand trial, if a due process hearing is given and the state’s reasons are more compelling than the subject’s reasons for refusing. The Sell decision also sheds light on what issues an impartial hearing body such as the Mental Health Board should consider when weighing the issue of forced medication, including:

- whether the medication is medically appropriate
- whether any alternative treatments are likely to succeed
- the likelihood and severity of drug side effects
- the likelihood of long term impact on the patient’s health
- whether the medication is likely to produce significant improvements
- whether the refusal to take the drug puts the patient or others at risk.

Constitutional rights apply to all citizens of the US. Moreover, civilly committed patients have the same Constitutional protections as do criminal defendants. Mills stands for the proposition that civilly committed patients enjoy Due Process protections in this regard. The same considerations that were applied in Sell are also applicable to Mental Health Board hearings on forced medication decisions. Basic Due Process protections would include a right to notice of the hearing, the medication that the State wishes to administer and an opportunity to defend his or her refusal to take that particular medication.

Even though the Nebraska statutory provision, 71-959(3) was enacted in 2004, the US Constitutional law that underpins the statute goes back over 23 years.

It should be clear from the foregoing that an attempt by the Mental Health Board to include “boilerplate” language in a commitment order granting the blanket authority to force medicate without first addressing the issues covered in this memo will not pass constitutional scrutiny. The subject is entitled to a due process hearing on these issues before a forced medication order can be entered in order to be consistent with the statutory and constitutional scheme.

Access by Law Enforcement to Mental Health Board File

Can law enforcement access the Mental Health Board’s File or other documents held by the Mental Health Board?

NRS Sec.71961 (1) Provides:

All records kept on any subject shall remain confidential except as otherwise provided by law. Such records shall be accessible to (a) the subject, except as otherwise provided in subsection (2) of this section, (b) the subject’s legal counsel, (c) the subject’s guardian or conservator, if any, (d) the mental health board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject (g) agents or employees of the Department of Health and Human Services Regulation and Licensure upon delivery of a subpoena from the department in connection with a licensing or licensure investigation by the department, or (h) the Nebraska State Patrol or the Department of Health and Human Services pursuant to section 69-2409.01

The phrase “all records kept on any subject” is not specifically delineated in statute, but reasonably includes records in the possession of the Mental Health Board as well as the file and other documents maintained by clerk of the district court (see 71-917).

Nothing in the statutes gives any law enforcement agency automatic access to such confidential records, absent one of the exceptions set forth in 71-961 (1). Put another way, without one of the exceptions in 71-961(1) having first been met, the mental health board has no authority to release its records to law enforcement. Note that per subsection (e), the Board can be authorized to release information per a court order. A court order is not a subpoena. If a law enforcement agent presents a subpoena for records in the possession of the Board, that alone would *not* authorize release.

Pursuant to section 69-2409.01, the Nebraska State Patrol is granted very limited access, upon request, “information as may be necessary for the sole purpose of determining whether an individual is disqualified from purchasing or possessing a handgun pursuant to state or federal law.” Such information, according to the foregoing statute, “Shall be furnished by the Department of Health and Human Services”. Thus, nothing in statute authorizes the mental health board to furnish information in its possession to law enforcement.

Statutory Role of MHB Duties and Responsibilities

According to 71-905, “mental health board” means a board created under section 71-915.

Synopsis of NRS Sec. 71-915

Subsection 1 Creation

The presiding judge in each district court judicial district shall create at least one but not more than three mental health boards in such district and shall appoint sufficient members and alternate members to such boards. Terms are for 4 years but the presiding judge may remove members/alternates at his discretion.

Immunity

Members of the MHB shall have the same immunity as judges of the District Court.

Subsection 2

Composition

Each MHB shall consist of a licensed attorney and any two of the following but not more than one from each category:

Physician

Psychologist

Psychiatric social worker

Psychiatric nurse

Clinical social worker

Layperson with a demonstrated interest in mental health and substance dependency issues.

Chairperson

The attorney shall be chairperson of the board.

Oath

Members/alternates shall take an oath to support the US and Nebraska Constitution and to faithfully discharge the duties of the office.

Subsection 3

Powers

MHB shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties.

Presence of Members Required/ Majority Vote

No MHB hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any MHB hearing shall be by a majority vote.

Subsection 4

Duty to File Inventory

MHB shall file an annual inventory statement with the county board of all county personal property in its custody.

Compensation/Reimbursement

Members of the MHB shall be compensated and reimbursed for actual and necessary expenses, not including charges for meals, by the county served by such board. Compensation shall be at an hourly rate determined by the presiding district court judge, except that compensation shall not be less than fifty dollars for each hearing of the board.

Synopsis of NRS Sec. 71-916

Subsection 1

Training by HHS

HHS shall provide training to members/alternates. No person shall remain on a MHB or be eligible for appointment unless he/she has attended and satisfactorily completed such training pursuant to rules and regulations adopted by HHS.

Reimbursement

Members/alternates shall be reimbursed for any actual and necessary expenses incurred in attending such training in an amount determined by the presiding judge of the district court.

Forms

HHS shall provide the MHB's with blank forms and copies of rules and regulations of the department that will enable the MHB's to carry out their powers and duties.

INSTRUCTIONS FOR SELF-STUDY REQUIRED EXAM

The Self study handbook and appendices must be read prior to completing the self study exam. The exam is based on the information in the self-study handbook and appendix. It is recommended that 75% of the questions be answered correctly for a satisfactory completion of Mental Health Board training.

Complete all of the questions on the Self Study exam. You may use any of the materials in the Self Study Handbook to answer the questions. Be sure to answer all the questions as completely as possible. Write, print legibly, or type so you will be given full credit for your answer. If your answer cannot be easily read, it will not be scored.

The self-study exam must be completed, sent and received in the Division of Behavioral Health Services. Your certificate will be mailed to you after your exam is scored. If you have any questions regarding the Self Study please contact Kathleen Samuelson at 402 475-5575 or Dan Powers at 402 479-5193.

Send your completed self-study exam to:

**Kathleen Samuelson or Dan Powers
MH Board Training Coordinators
Division of Behavioral Health Services
P.O. Box 98925
Lincoln, NE 68509-8925**

Mental Health Board Training
SELF STUDY EXAM

Name: _____
Address: _____
City: _____ State: NE Zip Code _____
Judicial District: _____ Mental Health Board: _____
Classification(attorney, physician, layperson, etc) _____

Multiple Choice (circle the one correct answer):

1. The level of evidence necessary for commitment is:
 - A. Beyond reasonable doubt
 - B. Clear and convincing
 - C. Clear and unequivocal
 - D. Preponderance of the evidence
2. To commit an individual he/she must be found to be:
 - A. Dangerous
 - B. Mentally ill or substance dependent
 - C. A and B
 - D. Intoxicated
3. In Wickwire's case the court ruled that a mental health board:
 - A. May commit persons with mental illness
 - B. May commit persons with mental illness only if they are substance abusers
 - C. May not commit people with mental retardation
 - D. May commit persons with mental retardation if they are dangerous
4. Mental Illness is a:
 - A. Thinking disorder
 - B. Mood disorder
 - C. Substance dependence
 - D. All of these
5. The four factors in dangerousness are:
 - A. Magnitude, likelihood, imminence, frequency
 - B. Age, intelligence, gender, social class
 - C. magnitude, likelihood, intelligence and frequency
 - D. Diagnosis, prognosis, insight, orientation
6. The best predictor of violence is:
 - A. A past history of violence
 - B. A DSM diagnosis
 - C. A law enforcement officer
 - D. A board certified psychiatrist
7. The percentage of overall violence in society attributable to mentally ill or dependent persons is:
 - A. .05%
 - B. 3%
 - C. 10%
 - D. 25%
8. The greatest potential for danger is represented by:

- A. Breaking objects
 - B. Making threats of violence toward others
 - C. Attacking others causing physical injury
 - D. Hitting a wall with a fist
9. The dangers to self include:
 - A. Drug and alcohol dependence
 - B. Suicide
 - C. Self neglect
 - D. All of the above
10. A symptom of substance dependency is:
 - A. Intoxication
 - B. Inability to stop using a substance
 - C. Using alcohol
 - D. Substance abuse
11. A mental health board should reevaluate a commitment decision when:
 - A. Never--reconsideration is not allowed by law
 - B. The person is not following outpatient treatment plan
 - C. The person has been waiting for placement after committal
 - D. Both B and C
12. The definition of dual disorder or dual diagnosis is:
 - a. Diagnosis of alcohol and drug dependency
 - b. Diagnosis of minor depression and substance abuse
 - c. Diagnosis of severe and persistent mental illness and substance dependency
 - d. Diagnosis of severe and persistent mental illness and substance use disorder
13. The definition of co-occurring disorder is:
 - A. Diagnosis of primary alcohol use and secondary substance dependency
 - B. Diagnosis of primary substance abuse disorder and secondary depression
 - C. Diagnosis of primary substance dependency and primary SPMI
 - D. Diagnosis of primary anxiety disorder and secondary behavior problems
14. Briefly describe the difference between dual disorder treatment and dual enhanced treatment.

15. The Mental Health Commitment Act considers _____ to be the treatment placement that should be considered last.
 - A. Least restrictive level of care
 - B. Outpatient level of care
 - C. Most restrictive level of care
 - D. Community based substance addiction level of care
16. True or False: In the commitment process a substance dependent person is considered a mentally ill person.

True

False

17. True or False: Risk of violence is greatest in mental illness when delusions cause hallucinations to make sense to a person.

True

False

18. True or False: A person who talks openly about suicide will not make an attempt.

True

False

19. True or False: A person with suicidal ideation really wants to die.

True

False

20. True or False: Blackouts are a symptom of alcohol dependence/alcoholism.

True

False

21. List three rights of a subject at a mental health board hearing.

(1)

(2)

(3)

22. List 3 questions you will ask the subject and/or the mental health/substance abuse professional at the next mental health board hearing:

(1)

(2)

(3)

23. Identify one change you will personally make in your commitment decision making process at the next mental health board hearing, because of the information presented in this study guide?

24. When mental health boards commit an individual to an inpatient (acute or sub-acute) level of care, the order places the individual into the custody of:

(1) A given regional center

(2) A given provider

(3) A given community hospital

(4) Department of Health and Human Services

25. Medication can be “forced” on a committed individual under which of the following circumstances? Choose all that may apply.

- (1) In an emergency to prevent injury to self or others
 - (2) When the treating physician determines it is in the best interest of the individual
 - (3) Following a hearing and order of a mental health board that such treatment medication will substantially improve the mental illness
 - (4) To help the individual assist in their defense at a hearing.
26. The majority of apprehended sex offenders have which of the following DSM diagnoses (choose all that may apply):
- a. voyeurism
 - b. pedophilia
 - c. sexual sadism
 - d. exhibitionism
 - e. sexual masochism
27. Pedophilia is often associated with which of the following co-occurring personality disorders (choose all that may apply):
- a. dependent
 - b. schizotypal
 - c. obsessive compulsive
 - d. antisocial
 - e. histrionic
28. The recidivism rate for persons with pedophilia with a preference for boys is:
- a. the same as for those with a preference for girls
 - b. less than for those with a preference for girls
 - c. more than for those with a preference for girls

Please read the following two case scenarios and answer all questions as completely as possible. PLEASE WRITE OR PRINT LEGIBLY OR TYPE ON A SEPARATE SHEET OF PAPER.

29. CASE SCENARIO #1

A 40 year-old male was EPC'd from his home in a rural trailer park; he had called a friend after the bar closed Friday night and said he might as well kill himself. The friend called the police; they found a loaded shotgun by the back door. The man told police he was becoming more depressed, had reached the end of his rope, was way behind on his bills and didn't see a way to catch up.

After two days in the Crisis Center, the man now denies feeling suicidal. He shows some signs of depression: difficulty concentrating, feelings of helplessness, excessive sleep. However, until the incident he had continued to work and had gone to the bar every night at 5 p.m. He admitted smoking marijuana every now and then, "just to relax." He denies he has a drinking problem, since all his friends go to the bar after work. He has no psychotic symptoms, no violence history, the only legal involvement was a DUI last month. He is physically healthy, had not been taking any prescribed medications, has not had any previous mental health or substance abuse treatment.

His mental health diagnosis is:

Axis I Major depressive disorder, single episode, mild
Alcohol abuse, Cannabis abuse

Axis II Deferred

Axis III Asthma

Axis IV Difficulties with primary support, economic problems

Axis V GAF 55

- A. What questions would you ask a clinician about the subject's diagnosis to help determine if mental illness is present. Explain why you would ask each question.
- B. What questions would you ask to help you determine dangerousness?
- C. What evidence of magnitude, likelihood, imminence and frequency is present?
- D. What decision regarding commitment and level of care/services do you believe would be appropriate for this man? List your reasons for your decision.

30. CASE SCENARIO #2

A 21 year-old female is brought to the Crisis Center after she was found rummaging through the trash behind Wal-Mart. She was seen roaming the parking lot, talking and gesturing to herself. She refuses to answer any direct questions, continues to hum under her breath, is dirty, disheveled, and dressed inappropriately for winter weather. She stated that she knows the staff can read her mind, so she is humming to confuse them. After a physical exam, she is found to be malnourished and underweight. The consulting psychiatrist requests a mental health board hearing after she has been on the unit for two days because she has refused to take any medication, claiming that the staff is being paid to poison her. She has an aunt and uncle living in a small town thirty miles away. When reached, they state she was enrolled at the local community college but had not been in contact with them for several weeks. As far as they know she has not used drugs, has never seen a psychiatrist, has no previous history of bizarre behavior.

Her mental health diagnosis is:

Axis I Paranoid Schizophrenia

Axis II Deferred

Axis III Malnutrition

Axis IV Primary support, economics, social, accessing medical care

Axis V GAF 25

- A. What questions would you ask clinician about subject's diagnosis?

- B. What questions would you ask to determine level of dangerousness?

- C. What evidence of dangerousness is present? Is the risk low, moderate, or extreme? Explain why you think low, moderate or extreme risk level in your answer.

- D. What decision regarding care/services would be appropriate for this young woman? List your reasons for your decision.

REFERENCES

- American Association of Community Psychiatrists (1997), "Level of Care Utilization System for Psychiatric and Addiction Services." May 17, 1997
- Cantor, C.H. and P.J. Baume (1999). "Suicide prevention: a public health approach." Aust NZ J Ment Health Nurs 8(2): 45-50.
- Dixon, L.B., and J.M. DeVeau (1999). "Dual Diagnosis: the double challenge." NAMI Advocate (April/May): 16-17.
- Goldney, R.D. (2000). "The privilege and responsibility of suicide prevention." Crisis 21(1): 8-15.
- Lyons, C.P. Price et al. (2000). "Suicide risk assessment: a review of procedures." Accid Emerg Nurs 8(3): 178-186.
- Patterson, W.M., H.H. Dohn et al. (1983). "Evaluation of suicidal patients: the SAD PERSONS scale." Psychometrics 24(4): 343-5, 348-9.
- Robie, D., E.J. Edgemon-Hill, et al. (1999). "Suicide prevention protocol." Am J. Nurs 99(12): 53-5, 57.
- Stack, S. (2000). "Suicide: a 15-year review of the sociological literature. Part I: Cultural and economic factors [In Process Citation]." Suicide Life Threat Behav 30(2):145-62.
- Stack, S. (2000). "Suicide: a 15-year review of the sociological literature. Part II: Modernization and social integration perspectives [In Process Citation]." Suicide Life Threat Behav 30(2):163-76.

APPENDIX A

Nebraska Mental Health Commitment Act

MENTAL HEALTH COMMITMENT ACT

71-901 Act, how cited.

Sections 71-901 to 71-962 shall be known and may be cited as the Nebraska Mental Health Commitment Act.

Source: Laws 1976, LB 806, § 89; Laws 1988, LB 257, § 6; Laws 1994, LB 498, § 12; Laws 1996, LB 1155, § 116; R.S.1943, (1999), § 83-1078; Laws 2004, LB 1083, § 21. Operative date July 1, 2004.

71-902 Declaration of purpose.

The purpose of the Nebraska Mental Health Commitment Act is to provide for the treatment of persons who are mentally ill and dangerous. It is the public policy of the State of Nebraska that mentally ill and dangerous persons be encouraged to obtain voluntary treatment. If voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment only after mental health board proceedings as provided by the Nebraska Mental Health Commitment Act. Such persons shall be subjected to emergency protective custody under limited conditions and for a limited period of time.

Source: Laws 1976, LB 806, § 1; Laws 1996, LB 1155, § 93; R.S.1943, (1999), § 83-1001; Laws 2004, LB 1083, § 22. Operative date July 1, 2004.

Cross Reference:

Persons supposed mentally ill, limitations on restraint of liberty, see section 83-357.

71-903 Definitions, where found.

For purposes of the Nebraska Mental Health Commitment Act, unless the context otherwise requires, the definitions found in sections 71-904 to 71-914 shall apply.

Source: Laws 1976, LB 806, § 2; Laws 1994, LB 498, § 4; R.S.1943, (1999), § 83-1002; Laws 2004, LB 1083, § 23. Operative date July 1, 2004.

71-904 Administrator, defined.

Administrator means the administrator or other chief administrative officer of a treatment facility or his or her designee.

Source: Laws 1976, LB 806, § 5; R.S.1943, (1999), § 83-1005; Laws 2004, LB 1083, § 24. Operative date July 1, 2004.

71-905 Mental health board, defined.

Mental health board means a board created under section 71-915.

Source: Laws 1976, LB 806, § 4; R.S.1943, (1999), § 83-1004; Laws 2004, LB 1083, § 25. Operative date July 1, 2004.

71-906 Mental health professional, defined.

Mental health professional means a person licensed to practice medicine and surgery or psychology in this state under the Uniform Licensing Law or an advanced practice registered nurse licensed under the Advanced Practice Registered Nurse Act who has proof of current certification in a psychiatric or mental health specialty.

Source: Laws 1976, LB 806, § 10; Laws 1991, LB 10, § 6; Laws 1994, LB 1210, § 159; R.S. 1943, (1999), § 83-1010; Laws 2004, LB 1083, § 26; Laws 2005, LB 534, § 1.

Effective date September 4, 2005.

Cross References

Advanced Practice Registered Nurse Act, see section 71-1704.

Uniform Licensing Law, see section 71-101.

The opinion of a general practitioner of medicine as to mental conditions is admissible in commitment proceedings, provided a proper foundation is laid. *Lux v. Mental Health Board of Polk County*, 202 Neb. 106, 274 N.W.2d 141 (1979).

71-907 Mentally ill, defined.

Mentally ill means having a psychiatric disorder that involves a severe or substantial impairment of a person's thought processes, sensory input, mood balance, memory, or ability to reason which substantially interferes with such person's ability to meet the ordinary demands of living or interferes with the safety or well-being of others.

Source: Laws 1977, LB 204, § 27; R.S.1943, (1999), § 83-1009.01; Laws 2004, LB 1083, § 27. Operative date July 1, 2004.

71-908 Mentally ill and dangerous person, defined.

Mentally ill and dangerous person means a person who is mentally ill or substance dependent and because of such mental illness or substance dependence presents: (1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or (2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

Source: Laws 1976, LB 806, § 9; Laws 1977, LB 204, § 26; Laws 1985, LB 252, § 2; R.S.1943, (1999), § 83-1009; Laws 2004, LB 1083, § 28. Operative date July 1, 2004.

Annotations:

1. Requirements of section

2. Evidentiary issues

3. Standard of proof

4. Constitutionality

1. Requirements of section

Involuntary commitment as a mentally ill dangerous person is improper when, although a person is clearly mentally ill, there is no showing of dangerousness. *Petersen v. County Board of Mental Health*, 203 Neb. 622, 279 N.W.2d 844 (1979).

Showing that a person is a spendthrift and improvident is insufficient to demonstrate dangerousness as required by this statute. *Petersen v. County Board of Mental Health*, 203 Neb. 622, 279 N.W.2d 844 (1979).

The requirements of this section, which defines a mentally ill dangerous person, are met when medical diagnoses of paranoid schizophrenia and an unprovoked assault and threatening behavior are shown by clear and convincing proof. *Lux v. Mental Health Board of Polk County*, 202 Neb. 106, 274 N.W.2d 141 (1979).

2. Evidentiary issues

Actions and statements of a person alleged to be mentally ill and dangerous which occur prior to the hearing are probative of the subject's present mental condition. However, in order for a past act to have any evidentiary value, it must form some foundation for a prediction of future dangerousness and be, therefore, probative of that issue. *In re Interest of Rasmussen*, 236 Neb. 572, 462 N.W.2d 621 (1990).

In proving the dangerousness of a mentally ill person as manifested by "evidence of inability to provide for his basic human needs," within the meaning of this section, expert testimony may be used to prove such a condition. *In re Interest of Kinnebrew*, 224 Neb. 885, 402 N.W.2d 264 (1987).

An act occurring five years prior to the mental health commitment hearing is recent within the meaning of this section where: (a) There is evidence that the act is still probative of the subject's future dangerousness; (b) the subject has not had an opportunity to commit a more recent act because he has been in confinement; and (c) there is reliable medical evidence that there is a high probability of repetition of such act by the subject. Under Mental Health Commitment Act, the determination of whether an act of violence is recent must be decided on the basis of all the surrounding facts and circumstances. *In re Interest of Blythman*, 208 Neb. 51, 302 N.W.2d 666 (1981).

An act or threat is "recent" within the meaning of this section, if the time interval between it and the hearing of the mental health board is not greater than that which would indicate processing

of the complaint was carried on with reasonable diligence under the circumstances existing having due regard for the rights and welfare of the alleged mentally ill dangerous person and the protection of society in general. *Hill v. County Board of Mental Health, Douglas County*, 203 Neb. 610, 279 N.W.2d 838 (1979).

Although this section refers to "recent violent acts," commitment may be based upon evidence of only one violent act or threat. *Lux v. Mental Health Board of Polk County*, 202 Neb. 106, 274 N.W.2d 141 (1979).

3. Standard of proof

The State must prove by clear and convincing evidence that an individual poses a substantial risk of harm to others or to himself to have that individual declared mentally ill and dangerous under the Nebraska Mental Health Commitment Act. *In re Interest of Dickson*, 238 Neb. 148, 469 N.W.2d 357 (1991).

Evidence must be clear and convincing to support a finding that a person is mentally ill and dangerous. *In re Interest of Rasmussen*, 236 Neb. 572, 462 N.W.2d 621 (1990).

4. Constitutionality

The definitions of mentally ill dangerous persons in the Nebraska Mental Health Commitment Act and the statutes governing persons acquitted of a crime on grounds of insanity are constitutional and do not violate equal protection guarantees. *Tulloch v. State*, 237 Neb. 138, 465 N.W.2d 448 (1991).

71-909 Outpatient treatment, defined.

Outpatient treatment means treatment ordered by a mental health board directing a subject to comply with specified outpatient treatment requirements, including, but not limited to, (1) taking prescribed medication, (2) reporting to a mental health professional or treatment facility for treatment or for monitoring of the subject's condition, or (3) participating in individual or group therapy or educational, rehabilitation, residential, or vocational programs.

Source: Laws 1994, LB 498, § 5; R.S.1943, (1999), § 83-1007.01; Laws 2004, LB 1083, § 29. Operative date July 1, 2004.

71-910 Peace officer or law enforcement officer, defined.

Peace officer or law enforcement officer means a sheriff, a jailer, a marshal, a police officer, or an officer of the Nebraska State Patrol.

Source: Laws 1976, LB 806, § 11; Laws 1981, LB 95, § 5; Laws 1988, LB 1030, § 52; R.S.1943, (1999), § 83-1011; Laws 2004, LB 1083, § 30. Operative date July 1, 2004.

71-911 Regional center, defined.

Regional center means a state hospital for the mentally ill as designated in section 83-305.

Source: Laws 1976, LB 806, § 7; R.S.1943, (1999), § 83-1007; Laws 2004, LB 1083, § 31. Operative date July 1, 2004.

71-912 Subject, defined.

Subject means any person concerning whom a certificate or petition has been filed under the Nebraska Mental Health Commitment Act. Subject does not include any person under eighteen years of age unless such person is an emancipated minor.

Source: Laws 1976, LB 806, § 14; Laws 1996, LB 1155, § 94; R.S.1943, (1999), § 83-1014; Laws 2004, LB 1083, § 32. Operative date July 1, 2004.

71-913 Substance dependent, defined.

Substance dependent means having a behavioral disorder that involves a maladaptive pattern of repeated use of controlled substances, illegal drugs, or alcohol, usually resulting in increased tolerance, withdrawal, and compulsive using behavior and including a cluster of cognitive, behavioral, and physiological symptoms involving the continued use of such substances despite significant adverse effects resulting from such use.

Source: Laws 1985, LB 252, § 3; R.S.1943, (1999), § 83-1009.02; Laws 2004, LB 1083, § 33. Operative date July 1, 2004.

71-914 Treatment facility, defined.

Treatment facility means a facility which is licensed to provide services for persons who are mentally ill or substance dependent or both.

Source: Laws 1976, LB 806, § 6; Laws 1985, LB 252, § 1; Laws 1995, LB 275, § 24; R.S.1943, (1999), § 83-1006; Laws 2004, LB 1083, § 34. Operative date July 1, 2004.

71-915 Mental health boards; created; powers; duties; compensation.

(1) The presiding judge in each district court judicial district shall create at least one but not more than three mental health boards in such district and shall appoint sufficient members and alternate members to such boards. Members and alternate members of a mental health board shall be appointed for four-year terms. The presiding judge may remove members and alternate members of the board at his or her discretion. Vacancies shall be filled for the unexpired term in the same manner as provided for the original appointment. Members of the mental health board shall have the same immunity as judges of the district court.

(2) Each mental health board shall consist of an attorney licensed to practice law in this state and any two of the following but not more than one from each category: A physician, a psychologist, a psychiatric social worker, a psychiatric nurse, a clinical social worker, or a layperson with a demonstrated interest in mental health and substance dependency issues. The attorney shall be chairperson of the board. Members and alternate members of a mental health board shall take and subscribe an oath to support the United States Constitution and the Constitution of Nebraska and to faithfully discharge the duties of the office according to law.

(3) The mental health board shall have the power to issue subpoenas, to administer oaths, and to do any act necessary and proper for the board to carry out its duties. No mental health board hearing shall be conducted unless three members or alternate members are present and able to vote. Any action taken at any mental health board hearing shall be by majority vote.

(4) The mental health board shall prepare and file an annual inventory statement with the county board of its county of all county personal property in its custody or possession. Members of the mental health board shall be compensated and shall be reimbursed for their actual and necessary expenses by the county or counties being served by such board. Compensation shall be at an hourly rate to be determined by the presiding judge of the district court, except that such compensation shall not be less than fifty dollars for each hearing of the board. Members shall also be reimbursed for their actual and necessary expenses, not including charges for meals. Mileage shall be determined pursuant to section 23-1112.

Source: Laws 1976, LB 806, § 27; Laws 1981, LB 95, § 7; Laws 1990, LB 822, § 39; Laws 1994, LB 498, § 6; R.S.1943, (1999), § 83-1017; Laws 2004, LB 1083, § 35. Operative date July 1, 2004.

71-916 Mental health board; training; Director of Health and Human Services; duties.

(1) The Department of Health and Human Services shall provide appropriate training to members and alternate members of each mental health board and shall consult with consumer and family advocacy groups in the development and presentation of such training. Members and alternate members shall be reimbursed for any actual and necessary expenses incurred in attending such training in a manner and amount determined by the presiding judge of the district court. No person shall remain on a mental health board or be eligible for appointment or reappointment as a member or alternate member of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by the department.

(2) The Director of Health and Human Services shall provide the mental health boards with blanks for warrants, certificates, and other forms and printed copies of applicable rules and regulations of the department that will enable the boards to carry out their powers and duties under the Nebraska Mental Health Commitment Act.

Source: Laws 2004, LB 1083, § 36. Operative date July 1, 2004.

71-917 Clerk of the district court; duties relating to mental health board.

The clerk of the district court appointed for that purpose by a district judge of that district court judicial district shall sign and issue all notices, appointments, warrants, subpoenas, or other process required to be issued by the mental health board and shall affix his or her seal as clerk of the district court. The clerk shall file and preserve in his or her office all papers connected with any proceedings of the mental health board and all related notices, reports, and other communications. The clerk shall keep minutes of all proceedings of the board. All required notices, reports, and communications may be sent by mail unless otherwise provided in the Nebraska Mental Health Commitment Act. The fact and date that such notices, reports, and communications have been sent and received shall be noted on the proper record.

Source: Laws 1976, LB 806, § 16; Laws 1981, LB 95, § 6; Laws 2000, LB 884, § 5; R.S.Supp.,2002, § 83-1016; Laws 2004, LB 1083, § 37. Operative date July 1, 2004.

71-918 Facility or programs for treatment of mental illness or substance dependence; voluntary admission; unconditional discharge; exception.

Any person may voluntarily apply for admission to any public or private hospital, other treatment facility, or program for treatment of mental illness or substance dependence in accordance with the regulations of such facilities or programs governing such admissions. Any person who is voluntarily admitted for such treatment shall be unconditionally discharged from such hospital, treatment facility, or program not later than forty-eight hours after delivery of his or her written request to any official of such hospital, treatment facility, or program, unless action is taken under the Nebraska Mental Health Commitment Act to continue his or her custody.

Source: Laws 1976, LB 806, § 29; Laws 1978, LB 501, § 1; Laws 1985, LB 252, § 4; Laws 2000, LB 884 § 6; R.S.Supp.,2002, § 83-1019; Laws 2004, LB 1083, § 38. Operative date July 1, 2004.

71-919 Mentally ill and dangerous person; emergency protective custody; evaluation by mental health professional.

(1) A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous and that the harm described in section 71-908 is likely to occur before mental health board proceedings under the Nebraska Mental Health Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person

is mentally ill and dangerous may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person.

(2) Upon admission to a medical facility of a person taken into emergency protective custody by a law enforcement officer under this section, such officer shall execute a written certificate prescribed and provided by the Director of Health and Human Services. The certificate shall allege the officer's belief that the person in custody is mentally ill and dangerous and shall contain a summary of the person's behavior supporting such allegations. A copy of such certificate shall be immediately forwarded to the county attorney.

(3) The administrator of the facility shall have such person evaluated by a mental health professional as soon as reasonably possible but not later than thirty-six hours after admission. The mental health professional shall not be the mental health professional who causes such person to be taken into custody under this section and shall not be a member or alternate member of the mental health board that will preside over any hearing under the Nebraska Mental Health Commitment Act with respect to such person. A person shall be released from emergency protective custody after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous.

Source: Laws 1976, LB 806, § 30; Laws 1978, LB 501, § 2; Laws 1988, LB 257, § 2; Laws 1996, LB 1044, § 964; Laws 1996, LB 1155, § 95; R.S.1943, (1999), § 83-1020; Laws 2004, LB 1083, § 39. Operative date July 1, 2004.

71-920 Mentally ill and dangerous person; certificate of mental health professional; contents.

(1) A mental health professional who, upon evaluation of a person admitted for emergency protective custody under section 71-919, determines that such person is mentally ill and dangerous shall execute a written certificate as provided in subsection (2) of this section not later than twenty-four hours after the completion of such evaluation. A copy of such certificate shall be immediately forwarded to the county attorney.

(2) The certificate shall be in writing and shall include the following information:

- (a) The subject's name and address, if known;
- (b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next-of-kin, if known;
- (c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;
- (d) The name and address of any other person who may have knowledge of the subject's mental illness or substance dependence who may be called as a witness at a mental health board hearing with respect to the subject, if known;
- (e) The name and address of the medical facility in which the subject is being held for emergency protective custody and evaluation;
- (f) The name and work address of the certifying mental health professional;
- (g) A statement by the certifying mental health professional that he or she has evaluated the subject since the subject was admitted for emergency protective custody and evaluation; and

(h) A statement by the certifying mental health professional that, in his or her clinical opinion, the subject is mentally ill and dangerous and the clinical basis for such opinion.

Source: Laws 2004, LB 1083, § 40. Operative date July 1, 2004.

71-921 Person believes another to be a mentally ill and dangerous person; notify county attorney; petition; when.

(1) Any person who believes that another person is mentally ill and dangerous may communicate such belief to the county attorney. The filing of a certificate by a law enforcement officer under section 71-919 shall be sufficient to communicate such belief. If the county attorney concurs that such person is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by a mental health board is available or would suffice to prevent the harm described in section 71-908, he or she shall file a petition as provided in this section.

(2) The petition shall be filed with the clerk of the district court in any county within: (a) The judicial district in which the subject is located; (b) the judicial district in which the alleged behavior of the subject occurred which constitutes the basis for the petition; or (c) another judicial district in the State of Nebraska if authorized, upon good cause shown, by a district judge of the judicial district in which the subject is located. In such event, all proceedings before the mental health board shall be conducted by the mental health board serving such other county, and all costs relating to such proceedings shall be paid by the county of residence of the subject. In the order transferring such cause to another county, the judge shall include such directions as are reasonably necessary to protect the rights of the subject.

(3) The petition shall be in writing and shall include the following information:

(a) The subject's name and address, if known;

(b) The name and address of the subject's spouse, legal counsel, guardian or conservator, and next-of-kin, if known;

(c) The name and address of anyone providing psychiatric or other care or treatment to the subject, if known;

(d) A statement that the county attorney has probable cause to believe that the subject of the petition is mentally ill and dangerous;

(e) A statement that the beliefs of the county attorney are based on specific behavior, acts, attempts, or threats which shall be specified and described in detail in the petition; and

(f) The name and address of any other person who may have knowledge of the subject's mental illness or substance dependence and who may be called as a witness at a mental health board hearing with respect to the subject, if known.

Source: Laws 1976, LB 806, § 34; Laws 1981, LB 95, § 9; Laws 2000, LB 884, § 8; R.S.Supp.,2002, § 83-1024; Laws 2004, LB 1083, § 41. Operative date July 1, 2004.

71-922 Mental health board proceedings; commencement; custody; conditions; dismissal; when.

- (1) Mental health board proceedings shall be deemed to have commenced upon the earlier of (a) the filing of a petition under section 71-921 or (b) notification by the county attorney to the law enforcement officer who took the subject into emergency protective custody under section 71-920 or the administrator of the treatment center or medical facility having charge of the subject of his or her intention to file such petition. The county attorney shall file such petition as soon as reasonably practicable after such notification.
- (2) A petition filed by the county attorney under section 71-921 may contain a request for the emergency protective custody and evaluation of the subject prior to commencement of a mental health board hearing pursuant to such petition with respect to the subject. Upon receipt of such request and upon a finding of probable cause to believe that the subject is mentally ill and dangerous as alleged in the petition, the court or chairperson of the mental health board may issue a warrant directing the sheriff to take custody of the subject. If the subject is already in emergency protective custody under a certificate filed under section 71-919, a copy of such certificate shall be filed with the petition. The subject in such custody shall be held in the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.
- (3) The petition and all subsequent pleadings and filings in the case shall be entitled In the Interest of _____, Alleged to be Mentally Ill and Dangerous. The county attorney may dismiss the petition at any time prior to the commencement of the hearing of the mental health board under section 71-924, and upon such motion by the county attorney, the mental health board shall dismiss the petition.

Source: Laws 1976, LB 806, § 36; Laws 1981, LB 95, § 10; Laws 2000, LB 884, § 9; R.S.Supp., 2002, § 83-1026; Laws 2004, LB 1083, § 42; Laws 2005, LB 551, § 9.

Operative date: July 1, 2005.

71-923 Petition; summons; hearing; sheriff; duties; failure to appear; warrant for custody.

Upon the filing of the petition under section 71-921, the clerk of the district court shall cause a summons fixing the time and place for a hearing to be prepared and issued to the sheriff for service. The sheriff shall personally serve upon the subject and the subject's legal guardian or custodian, if any, the summons and copies of the petition, the list of rights provided by sections 71-943 to 71-960, and a list of the names, addresses, and telephone numbers of mental health professionals in that immediate vicinity by whom the subject may be evaluated prior to his or her hearing. The summons shall fix a time for the hearing within seven calendar days after the subject has been taken into emergency protective custody. The failure of a subject to appear as required under this section shall constitute grounds for the issuance by the mental health board of a warrant for his or her custody.

Source: Laws 1976, LB 806, § 37; Laws 1981, LB 95, § 11; Laws 1996, LB 1155, § 98; R.S.1943, (1999), § 83-1027; Laws 2004, LB 1083, § 43. Operative date July 1, 2004.

71-924 Hearing; mental health board; duties.

A hearing shall be held by the mental health board to determine whether there is clear and convincing evidence that the subject is mentally ill and dangerous as alleged in the petition. At the commencement of the hearing, the board shall inquire whether the subject has received a copy of the petition and list of rights accorded him or her by sections 71-943 to 71-960 and whether he or she has read and understood them. The board shall explain to the subject any part of the petition or list of rights which he or she has not read or understood. The board shall inquire of the subject whether he or she admits or denies the allegations of the petition. If the subject admits the allegations, the board shall proceed to enter a treatment order pursuant to section 71-925. If the subject denies the allegations of the petition, the board shall proceed with a hearing on the merits of the petition.

Source: Laws 1976, LB 806, § 45; Laws 1981, LB 95, § 14; R.S.1943, (1999), § 83-1035; Laws 2004, LB 1083, § 44. Operative date July 1, 2004.

71-925 Burden of proof; mental health board; hearing; orders authorized; conditions; rehearing.

(1) The state has the burden to prove by clear and convincing evidence that (a) the subject is mentally ill and dangerous and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm described in section 71-908.

(2) If the mental health board finds that the subject is not mentally ill and dangerous, the board shall dismiss the petition and order the unconditional discharge of the subject.

(3) If the mental health board finds that the subject is mentally ill and dangerous but that voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the mental health board are available and would suffice to prevent the harm described in section 71-908, the board shall (a) dismiss the petition and order the unconditional discharge of the subject or (b) suspend further proceedings for a period of up to ninety days to permit the subject to obtain voluntary treatment. At any time during such ninety-day period, the county attorney may apply to the board for reinstatement of proceedings with respect to the subject, and after notice to the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, the board shall hear the application. If no such application is filed or pending at the conclusion of such ninety-day period, the board shall dismiss the petition and order the unconditional discharge of the subject.

(4) If the subject admits the allegations of the petition or the mental health board finds that the subject is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the board are available or would suffice to

prevent the harm described in section 71-908, the board shall, within forty-eight hours, (a) order the subject to receive outpatient treatment or (b) order the subject to receive inpatient treatment. If the subject is ordered by the board to receive inpatient treatment, the order shall commit the subject to the custody of the Department of Health and Human Services for such treatment.

(5) A subject who (a) is ordered by the mental health board to receive inpatient treatment and (b) has not yet been admitted for such treatment pursuant to such order may petition for a rehearing by the mental health board based on improvement in the subject's condition such that inpatient treatment ordered by the board would no longer be necessary or appropriate.

(6) A treatment order by the mental health board under this section shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the subject. The board shall consider all treatment alternatives, including any treatment program or conditions suggested by the subject, the subject's counsel, or other interested person. Inpatient hospitalization or custody shall only be considered as a treatment alternative of last resort. The county attorney and the subject may jointly offer a proposed treatment order for adoption by the board. The board may enter the proposed order without a full hearing.

(7) The mental health board may request the assistance of the Department of Health and Human Services or any other person or public or private entity to advise the board prior to the entry of a treatment order pursuant to this section and may require the subject to submit to reasonable psychiatric and psychological evaluation to assist the board in preparing such order. Any mental health professional conducting such evaluation at the request of the mental health board shall be compensated by the county or counties served by such board at a rate determined by the district judge and reimbursed for mileage at the rate provided in section 81-1176.

Source: Laws 1976, LB 806, § 47; Laws 1978, LB 501, § 7; Laws 1981, LB 95, § 16; Laws 1996, LB 1155, § 102; R.S.1943, (1999), § 83-1037; Laws 2004, LB 1083, § 45. Operative date July 1, 2004.

Annotations:

The board of mental health's conclusion that a person before it is a mentally ill dangerous person and that a less restrictive alternative is not available or would not suffice to prevent the harm described in section 83-1009 must be supported by clear and convincing evidence. In re Interest of Vance, 242 Neb. 109, 493 N.W.2d 620 (1992).

In determining whether a person is dangerous, the focus must be on the subject's condition at the time of the hearing, not the date the subject of the commitment hearing was initially taken into custody. In re Interest of Rasmussen, 236 Neb. 572, 462 N.W.2d 621 (1990).

Statute requires proof that person is dangerous before he will be subject to involuntary confinement. Richards v. Douglas County, 213 Neb. 313, 328 N.W.2d 783 (1983).

71-926 Subject; custody pending entry of treatment order.

(1) At the conclusion of a mental health board hearing under section 71-924 and prior to the entry of a treatment order by the board under section 71-925, the board may (a) order that the subject be retained in custody until the entry of such order and the

subject may be admitted for treatment pursuant to such order or (b) order the subject released from custody under such conditions as the board deems necessary and appropriate to prevent the harm described in section 71-908 and to assure the subject's appearance at a later disposition hearing by the board. A subject shall be retained in custody under this section at the nearest appropriate and available medical facility and shall not be placed in a jail. Each county shall make arrangements with appropriate medical facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities.

(2) A subject who has been ordered to receive inpatient or outpatient treatment by a mental health board may be provided treatment while being retained in emergency protective custody and pending admission of the subject for treatment pursuant to such order.

Source: Laws 1976, LB 806, § 49; Laws 1988, LB 257, § 4; Laws 1996, LB 1044, § 967; Laws 1996, LB 1155, § 103; R.S.1943, (1999), § 83-1039; Laws 2004, LB 1083, § 46. Operative date July 1, 2004.

71-927 Mentally ill and dangerous subject; board; issue warrant; contents; immunity.

If the mental health board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment. The board shall issue a warrant authorizing the administrator of such treatment facility to receive and keep the subject as a patient. The warrant shall state the findings of the board and the legal settlement of the subject, if known, or any available information relating thereto. Such warrant shall shield every official and employee of the treatment facility against all liability to prosecution of any kind on account of the reception and detention of the subject if the detention is otherwise in accordance with the Nebraska Mental Health Commitment Act, rules and regulations adopted and promulgated under the act, and policies of the treatment facility.

Source:
Laws 1976, LB 806, § 51; Laws 1985, LB 252, § 5; Laws 1994, LB 337, § 1; R.S.1943, (1999), § 83-1041; Laws 2004, LB 1083, § 47. Operative date July 1, 2004.

71-928 Inpatient treatment; subject taken to facility; procedure.

When an order of a mental health board requires inpatient treatment of a subject within a treatment facility, the warrant filed under section 71-927, together with the findings of the mental health board, shall be delivered to the sheriff of the county who shall execute such warrant by conveying and delivering the warrant, the findings, and the subject to the treatment facility. The administrator, over his or her signature, shall acknowledge the delivery on the original warrant which the sheriff shall return to the clerk of the district court with his or her costs and expenses endorsed thereon. If neither the sheriff nor deputy sheriff is available to execute the warrant, the chairperson

of the mental health board may appoint some other suitable person to execute the warrant. Such person shall take and subscribe an oath or affirmation to faithfully discharge his or her duty and shall be entitled to the same fees as the sheriff. The sheriff, deputy sheriff, or other person appointed by the mental health board may take with him or her such assistance as may be required to execute the warrant. No female subject shall be taken to a treatment facility without being accompanied by another female or relative of the subject. The administrator in his or her acknowledgment of delivery shall record whether any person accompanied the subject and the name of such person.

Source: Laws 1976, LB 806, § 52; R.S.1943, (1999), § 83-1042; Laws 2004, LB 1083, § 48. Operative date July 1, 2004.

Cross Reference:

Sheriff, mileage and fees, see section 83-337.

71-929 Mental health board; execution of warrants; costs; procedure.

(1) If a mental health board issues a warrant for the admission or return of a subject to a treatment facility and funds to pay the expenses thereof are needed in advance, the board shall estimate the probable expense of conveying the subject to the treatment facility, including the cost of any assistance that might be required, and shall submit such estimate to the county clerk of the county in which such person is located. The county clerk shall certify the estimate and shall issue an order on the county treasurer in favor of the sheriff or other person entrusted with the execution of the warrant.

(2) The sheriff or other person executing the warrant shall include in his or her return a statement of expenses actually incurred, including any excess or deficiency. Any excess from the amount advanced for such expenses under subsection (1) of this section shall be paid to the county treasurer, taking his or her receipt therefor, and any deficiency shall be obtained by filing a claim with the county board. If no funds are advanced, the expenses shall be certified on the warrant and paid when returned.

(3) The sheriff shall be reimbursed for mileage at the rate provided in section 33-117 for conveying a subject to a treatment facility under this section. For other services performed under the Nebraska Mental Health Commitment Act, the sheriff shall receive the same fees as for like services in other cases.

(4) All compensation and expenses provided for in this section shall be allowed and paid out of the treasury of the county by the county board.

Source: Laws 2004, LB 1083, § 49. Operative date July 1, 2004.

71-930 Treatment order of mental health board; appeal; final order of district court; appeal.

The subject of a petition or the county attorney may appeal a treatment order of the mental health board under section 71-925 to the district court. Such appeals shall be de novo on the record. A final order of the district court may be appealed to the Court of Appeals in accordance with the procedure in criminal cases. The final judgment of the court shall be certified to and become a part of the records of the mental health board with respect to the subject.

Source: Laws 1976, LB 806, § 53; Laws 1991, LB 732, § 155; R.S.1943, (1999), § 83-1043; Laws 2004, LB 1083, § 50. Operative date July 1, 2004.

Annotations:

In reviewing a district court's judgment under this act, the Supreme Court will affirm the district court's judgment unless, as a matter of law, the judgment is unsupported by evidence which is clear and convincing. *In re Interest of Rasmussen*, 236 Neb. 572, 462 N.W.2d 621 (1990).

This section requires the district court to review appeals from the mental health board de novo on the record, and this court to hear appeals from the district court in accordance with criminal procedures. *In re Interest of Aandahl*, 219 Neb. 414, 363 N.W.2d 392 (1985).

A finding that the accused is incompetent to stand trial may be appealed to the Supreme Court as a final order. *State v. Guatney*, 207 Neb. 501, 299 N.W.2d 538 (1980).

The Supreme Court will not interfere on appeal with a final order made by the district court in mental health commitment proceedings unless it can say as a matter of law that the order is not supported by clear and convincing evidence. *Hill v. County Board of Mental Health, Douglas County*, 203 Neb. 610, 279 N.W.2d 838 (1979).

Commitment proceedings are judicial in nature and the District Courts must review the decisions of Mental Health Boards de novo on the record. *Lux v. Mental Health Board of Polk County*, 202 Neb. 106, 274 N.W.2d 141 (1979).

71-931 Treatment order; individualized treatment plan; contents; copy; filed; treatment; when commenced.

(1) Any treatment order entered by a mental health board under section 71-925 shall include directions for (a) the preparation and implementation of an individualized treatment plan for the subject and (b) documentation and reporting of the subject's progress under such plan.

(2) The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or substance dependence, (b) the least restrictive treatment alternative consistent with the clinical diagnosis of the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for the attainment of such goals.

(3) A copy of the individualized treatment plan shall be filed with the mental health board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, within five working days after the entry of the board's order. Treatment shall be commenced within two working days after preparation of the plan.

(4) The subject shall be entitled to know the contents of the individualized treatment plan and what the subject must do in order to meet the requirements of such plan.

(5) The subject shall be notified by the mental health board when the mental health board has changed the treatment order or has ordered the discharge of the subject from commitment.

Source: Laws 1976, LB 806, § 54; Laws 1978, LB 501, § 9; Laws 1981, LB 95, § 17; Laws 1996, LB 1155, § 105; R.S.1943, (1999), § 83-1044; Laws 2004, LB 1083, § 51. Operative date July 1, 2004.

71-932 Person responsible for subject's individualized treatment plan; periodic progress reports; copies; filed and served.

The person or entity designated by the mental health board under section 71-931 to prepare and oversee the subject's individualized treatment plan shall submit periodic reports to the mental health board of the subject's progress under such plan and any modifications to the plan. The mental health board may distribute copies of such reports to other interested parties as permitted by law. With respect to a subject ordered by the mental health board to receive inpatient treatment, such initial report shall be filed with the mental health board for review and inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. With respect to each subject committed by the mental health board, such reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Source: Laws 1976, LB 806, § 55; Laws 1978, LB 501, § 10; Laws 1996, LB 1155, § 106; R.S.1943, (1999), § 83-1045; Laws 2004, LB 1083, § 52. Operative date July 1, 2004.

71-933 Outpatient treatment provider; duties; investigation by county attorney; warrant for immediate custody of subject; when.

(1) Any provider of outpatient treatment to a subject ordered by a mental health board to receive such treatment shall report to the board and to the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the mental health board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or substance dependence. Such report may be transmitted by facsimile, but the original of the report shall be mailed to the board and the county attorney no later than twenty-four hours after the facsimile transmittal.

(2)(a) Upon receipt of such report, the county attorney shall have the matter investigated to determine whether there is a factual basis for the report.

(b) If the county attorney determines that there is no factual basis for the report or that no further action is warranted, he or she shall notify the board and the treatment provider and take no further action.

(c) If the county attorney determines that there is a factual basis for the report and that intervention by the mental health board is necessary to protect the subject or others,

the county attorney may file a motion for reconsideration of the conditions set forth by the board and have the matter set for hearing.

(d) The county attorney may apply for a warrant to take immediate custody of the subject pending a rehearing by the board under subdivision (c) of this subsection if the county attorney has reasonable cause to believe that the subject poses a threat of danger to himself or herself or others prior to such rehearing. The application for a warrant shall be supported by affidavit or sworn testimony by the county attorney, a mental health professional, or any other informed person. The application for a warrant and the supporting affidavit may be filed with the board by facsimile, but the original shall be filed with the board not later than three days after the facsimile transmittal, excluding holidays and weekends. Sworn testimony in support of the warrant application may be taken over the telephone at the discretion of the board.

Source: Laws 1994, LB 498, § 9; R.S.1943, (1999), § 83-1045.01; Laws 2004, LB 1083, § 53. Operative date July 1, 2004.

71-934 Outpatient treatment; hearing by board; warrant for custody of subject; subject's rights; board determination.

The mental health board shall, upon motion of the county attorney, or may, upon its own motion, hold a hearing to determine whether a subject ordered by the board to receive outpatient treatment can be adequately and safely served by the individualized treatment plan for such subject on file with the board. The mental health board may issue a warrant directing any law enforcement officer in the state to take custody of the subject and directing the sheriff or other suitable person to transport the subject to a treatment facility or public or private hospital with available capacity specified by the board where he or she will be held pending such hearing. No person may be held in custody under this section for more than seven days except upon a continuance granted by the board. At the time of execution of the warrant, the sheriff or other suitable person designated by the board shall personally serve upon the subject, the subject's counsel, and the subject's legal guardian or conservator, if any, a notice of the time and place fixed for the hearing, a copy of the motion for hearing, and a list of the rights provided by the Nebraska Mental Health Commitment Act. The subject shall be accorded all the rights guaranteed to a subject by the act. Following the hearing, the board shall determine whether outpatient treatment will be continued, modified, or ended.

Source: Laws 1994, LB 498, § 10; Laws 1996, LB 1155, § 107; R.S.1943, (1999), § 83-1045.02; Laws 2004, LB 1083, § 54. Operative date July 1, 2004.

71-935 Mental health board; review hearing; order discharge or change treatment disposition; when.

(1) Upon the filing of a periodic report under section 71-932, the subject, the subject's counsel, or the subject's legal guardian or conservator, if any, may request and shall be entitled to a review hearing by the mental health board and to seek from the board an order of discharge from commitment or a change in treatment ordered by the board. The mental health board shall schedule the review hearing no later than fourteen calendar days after receipt of such request. The mental health board may schedule a

review hearing (a) at any time pursuant to section 71-937 or 71-938, (b) upon the request of the subject, the subject's counsel, the subject's legal guardian or conservator, if any, the county attorney, the official, agency, or other person or entity designated by the mental health board under section 71-931 to prepare and oversee the subject's individualized treatment plan, or the mental health professional directly involved in implementing such plan, or (c) upon the board's own motion.

(2) The board shall immediately discharge the subject or enter a new treatment order with respect to the subject whenever it is shown by any person or it appears upon the record of the periodic reports filed under section 71-932 to the satisfaction of the board that (a) cause no longer exists for the care or treatment of the subject or (b) a less restrictive treatment alternative exists for the subject. When discharge or a change in disposition is in issue, due process protections afforded under the Nebraska Mental Health Commitment Act shall attach to the subject.

Source: Laws 1976, LB 806, § 56; Laws 1994, LB 498, § 11; Laws 1996, LB 1155, § 108; R.S.1943, (1999), § 83-1046; Laws 2004, LB 1083, § 55. Operative date July 1, 2004.

Annotations:

The Nebraska Mental Health Commitment Act clearly and plainly contemplates that due process be afforded at hearings other than the one held upon the filing of the initial petition. In re Interest of Powers, 242 Neb. 19, 493 N.W.2d 166 (1992).

Upon review of a commitment under this section, the State must prove by clear and convincing evidence that the individual remains mentally ill and dangerous. In re Interest of Dickson, 238 Neb. 148, 469 N.W.2d 357 (1991).

71-936 Regional center or treatment facility; administrator; discharge of involuntary patient; notice.

When the administrator of any regional center or treatment facility for the treatment of persons who are mentally ill or substance dependent determines that any involuntary patient in such facility may be safely and properly discharged or placed on convalescent leave, the administrator of such regional center or treatment facility shall immediately notify the mental health board of the judicial district from which such patient was committed.

Source: Laws 1967, c. 251, § 16, p. 670; Laws 1981, LB 95, § 4; R.S.1943, (1999), § 83-340.01; Laws 2004, LB 1083, § 56. Operative date July 1, 2004.

71-937 Mental health board; notice of release; hearing.

A mental health board shall be notified in writing of the release by the treatment facility of any individual committed by the mental health board. Such notice shall immediately be forwarded to the county attorney. The mental health board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is mentally ill and dangerous

and consequently not a proper subject for release. Such hearing shall be conducted in accordance with the procedures established for hearings under the Nebraska Mental Health Commitment Act. The subject of such hearing shall be accorded all rights guaranteed to the subject of a petition under the act.

Source: Laws 1981, LB 95, § 26; Laws 2003, LB 724, § 10; R.S.Supp.,2003, § 83-1079; Laws 2004, LB 1083, § 57. Operative date July 1, 2004.

71-938 Mental health board; person released from treatment; compliance with conditions of release; conduct hearing; make determination.

The mental health board shall, upon the motion of the county attorney, or may upon its own motion, hold a hearing to determine whether a person who has been ordered by the board to receive inpatient or outpatient treatment is adhering to the conditions of his or her release from such treatment, including the taking of medication. The subject of such hearing shall be accorded all rights guaranteed to a subject under the Nebraska Mental Health Commitment Act, and such hearing shall apply the standards used in all other hearings held pursuant to the act. If the mental health board concludes from the evidence at the hearing that there is clear and convincing evidence that the subject is mentally ill and dangerous, the board shall so find and shall within forty-eight hours enter an order of final disposition providing for the treatment of such person in accordance with section 71-925.

Source: Laws 1981, LB 95, § 27; R.S.1943, (1999), § 83-1080; Laws 2004, LB 1083, § 58. Operative date July 01, 2004.

71-939 Escape from treatment facility or program; notification required; contents; warrant; execution; peace officer; powers.

When any person receiving treatment at a treatment facility or program for persons with mental illness or substance dependence pursuant to an order of a court or mental health board is absent without authorization from such treatment facility or program, the administrator or program director of such treatment facility or program shall immediately notify the Nebraska State Patrol and the court or clerk of the mental health board of the judicial district from which such person was committed. The notification shall include the person's name and description and a determination by a psychiatrist, clinical director, administrator, or program director as to whether the person is believed to be currently dangerous to others. The clerk shall issue the warrant of the board directed to the sheriff of the county for the arrest and detention of such person. Such warrant may be executed by the sheriff or any other peace officer. Pending the issuance of the warrant of the mental health board, any peace officer may seize and detain such person when the peace officer has probable cause to believe that the person is reported to be absent without authorization as described in this section. Such person shall be returned to the treatment facility or program or shall be taken to a facility as described in section 71-919 until he or she can be returned to such treatment facility or program.

Source: Laws 1969, c. 215, § 10, p. 835; Laws 1976, LB 806, § 19; R.S.1943, (1994), § 83-308.02; Laws 1996, LB 1155, § 112; R.S.1943, (1999), § 83-1071; Laws 2004, LB 1083, § 59. Operative date July 1, 2004.

71-940 Person with mental illness or substance dependence; committed under other state's laws; return to other state; procedure; warrant issued.

The Governor may, upon demand from officials of another state, deliver to the executive authority of another state or his or her designee any person who is absent without authorization from a treatment facility or program for persons with mental illness or substance dependence to which such person has been committed under the laws of the other state either through civil commitment, as a result of being found not responsible for a criminal act by reason of insanity or mental illness, or as a result of being found not competent to stand trial for a criminal charge. The demand shall be accompanied by a certified copy of the commitment and sworn statement by the administrator of the treatment facility or program stating that (1) the person is absent without authorization, (2) the person is currently dangerous to himself, herself, or others, and (3) the demanding state is willing to accept the person back for further treatment. If the Governor is satisfied that the demand conforms to law, the Governor shall issue a warrant under seal of this state authorizing the return of such person to the demanding state at the expense of the demanding state.

Source: Laws 1996, LB 1155, § 113; R.S.1943, (1999), § 83-1072; Laws 2004, LB 1083, § 60. Operative date July 1, 2004.

71-941 Person with mental illness or substance dependence; arrested under warrant; notice; rights; writ of habeas corpus; hearing.

(1) A person arrested upon a warrant pursuant to section 71-940 shall not be delivered to a demanding state until he or she is notified of the demand for his or her surrender and has had an opportunity to apply for a writ of habeas corpus. If an application is filed, notice of the time and place for hearing on the writ shall be given to the county attorney of the county where the arrest was made. The person arrested shall have the right to counsel and the right to have counsel appointed for him or her if the person is indigent. Pending the determination of the court upon the application for the writ, the person detained shall be maintained in a suitable facility as described in section 71-919 or a hospital for persons with mental illness.

(2) At a hearing on a writ of habeas corpus, the State of Nebraska shall show that there is probable cause to believe that (a) such person is absent without authorization from a treatment facility or program for persons with mental illness or substance dependence to which he or she was committed located in the demanding state, (b) the demanding state has reason to believe that such person is currently dangerous to himself, herself, or others, and (c) the demanding state is willing to accept the person back for further treatment.

Source: Laws 1996, LB 1155, § 114; R.S.1943, (1999), § 83-1073; Laws 2004, LB 1083, § 61. Operative date July 1, 2004.

71-942 Person with mental illness or substance dependence; located outside state; demand return; procedure.

The Governor may appoint an agent to demand of the executive authority of another state any person who is located in such other state, who was receiving treatment at a treatment facility or program in this state pursuant to the Nebraska Mental Health Commitment Act or section 29-1823, 29-2203, or 29-3701 to 29-3704, and who is absent without authorization from such treatment facility or program. The demand shall be accompanied by a certified copy of the order of commitment and a sworn statement by the administrator of the treatment facility or program stating that (1) the person is absent without authorization, (2) the administrator or program director of such treatment facility or program believes that such person is currently dangerous to himself, herself, or others, and (3) the treatment facility or program is willing to accept the person back for further treatment. This section does not prevent extradition under the Uniform Criminal Extradition Act if such act applies.

Source: Laws 1996, LB 1155, § 115; R.S.1943, (1999), § 83-1074; Laws 2004, LB 1083, § 62. Operative date July 1, 2004.

Cross Reference:

Uniform Criminal Extradition Act, see section 29-758.

71-943 Subjects' rights during proceedings against them.

In addition to the rights granted subjects by any other provisions of the Nebraska Mental Health Commitment Act, such subjects shall be entitled to the rights provided in sections 71-943 to 71-960 during proceedings concerning the subjects under the act.

Source: Laws 1976, LB 806, § 57; Laws 2000, LB 884, § 10; R.S.Supp.,2002, § 83-1047; Laws 2004, LB 1083, § 63. Operative date July 1, 2004.

71-944 Subject's rights; written notice of the time and place of hearing; reasons alleged for treatment; procedure.

A subject shall, in advance of the mental health board hearing conducted under section 71-924, be entitled to written notice of the time and place of such hearing, the reasons alleged for believing that he or she is mentally ill and dangerous requiring inpatient or outpatient treatment ordered by the mental health board, and all rights to which such subject is entitled under the Nebraska Mental Health Commitment Act. The notice requirements shall be deemed satisfied by personal service upon the subject of the summons or notice of time and place of the hearing and copies of the petition and list of rights required by sections 71-923 and 71-924. If the subject has counsel and if the physician or mental health professional on the board determines that the nature of the alleged mental disorder, if true, is such that it is not prudent to disclose the label of the mental disorder to the subject, then notice of this label may be disclosed to the subject's

counsel rather than to the subject. When the subject does not have counsel, the subject has a right to the information about his or her mental illness including its label. The clerk shall issue the summons by order of the mental health board.

Source: Laws 1976, LB 806, § 58; Laws 1981, LB 95, § 18; Laws 2000, LB 884, § 11; R.S.Supp.,2002, § 83-1048; Laws 2004, LB 1083, § 64. Operative date July 1, 2004.

71-945 Subject's rights; representation by counsel; appointment of counsel if indigent.

A subject shall have the right to be represented by counsel in all proceedings under the Nebraska Mental Health Commitment Act. Counsel for a subject who is in custody shall have full access to and the right to consult privately with the subject at all reasonable times. As soon as possible after a subject is taken into emergency protective custody under section 71-919, or after the filing of a petition under section 71-921, whichever occurs first, and before the mental health board hearing conducted under section 71-924, the board shall determine whether the subject is indigent. If the subject is found to be indigent, the board shall certify that fact to the district or county court by causing to be delivered to the clerk of such court a certificate for appointment of counsel as soon as possible after a subject is taken into emergency protective custody or such petition is filed.

Source: Laws 1976, LB 806, § 59; Laws 1981, LB 95, § 19; Laws 2000, LB 884, § 12; R.S.Supp.,2002, § 83-1049; Laws 2004, LB 1083, § 65. Operative date July 1, 2004.

71-946 Appointment of counsel; procedure.

The appointment of counsel under section 71-945 shall be in accordance with the following procedures:

(1) Except in counties having a public defender, upon the receipt from the mental health board of a certificate for the appointment of counsel, the clerk of the district court shall notify the district judge or the county judge of the county in which the proceedings are pending of the receipt of such certificate. The judge to whom the certificate was issued shall appoint an attorney to represent the person concerning whom an application is filed before the mental health board, whereupon the clerk of the court shall enter upon the certificate the name of the attorney appointed and deliver the certificate of appointment of counsel to the mental health board. The clerk of the district court or the clerk of the county court shall also keep and maintain a record of all appointments which shall be conclusive evidence thereof. All appointments of counsel under the Nebraska Mental Health Commitment Act may be made at any time or place in the state; and

(2) In counties having a public defender, upon receipt from the mental health board of a certificate for the appointment of counsel, the clerk of the district court shall notify the public defender of his or her appointment to represent the person and shall enter upon the certificate the name of the attorney appointed and deliver the certificate of appointment of counsel to the mental health board.

Source: Laws 1976, LB 806, § 60; Laws 2000, LB 884, § 13; R.S.Supp.,2002, § 83-1050; Laws 2004, LB 1083, § 66. Operative date July 1, 2004.

71-947 Appointed counsel; fees; reimbursement of costs incurred; procedure.

Counsel appointed as provided in subdivision (1) of section 71-946 shall apply to the court in which his or her appointment is recorded for fees for services performed. Such counsel may also apply to the court to secure separate professional examination of the person for whom counsel was appointed and shall be reimbursed for costs incurred in securing such separate examination or examinations or in having other professional persons as witnesses before the mental health board. The court, upon hearing the application, shall fix reasonable fees, including reimbursement of costs incurred. The county board of the county in which the application was filed shall allow the account, bill, or claim presented by the attorney for services performed under the Nebraska Mental Health Commitment Act in the amount determined by the court. No such account, bill, or claim shall be allowed by the county board until the amount thereof has been determined by the court.

Source: Laws 1976, LB 806, § 61; Laws 2000, LB 884, § 14; R.S.Supp.,2002, § 83-1051; Laws 2004, LB 1083, § 67. Operative date July 1, 2004.

71-948 Subject's rights; independent evaluation and assistance in proceedings; fees and expenses.

A subject or the subject's counsel shall have the right to employ mental health professionals of his or her choice to independently evaluate the subject's mental condition and testify for and otherwise assist the subject in proceedings under the Nebraska Mental Health Commitment Act. If the subject is indigent, only one such person may be employed except with leave of the mental health board. Any person so employed by a subject determined by the board to be indigent, except a subject represented by the public defender, shall apply to the board for expenses reasonably necessary to such person's effective assistance of the subject and for reasonable fees for services performed by such person in assisting the subject. The board shall then fix reasonable fees and expenses, and the county board shall allow payment to such person in the full amount fixed by the board.

Source: Laws 1976, LB 806, § 62; Laws 1994, LB 1210, § 161; R.S.1943, (1999), § 83-1052; Laws 2004, LB 1083, § 68. Operative date July 1, 2004.

71-949 Counsel for subject; rights; enumerated; discovery; appeal from denial of discovery; when.

Counsel for a subject, upon request made to the county attorney at any time after the subject has been taken into emergency protective custody under the Nebraska Mental Health Commitment Act, or after the filing of a petition under section 71-921, whichever occurs first, shall have the right to be provided with (1) the names of all

witnesses expected to testify in support of the petition, (2) knowledge of the location and access at reasonable times for review or copying of all written documents including reports of peace officers, law enforcement agencies, and mental health professionals, (3) access to all other tangible objects in the possession of the county attorney or to which the county attorney has access, and (4) written records of any treatment facility or mental health professional which or who has at any time treated the subject for mental illness or substance dependence, which records are relevant to the issues of whether the subject is mentally ill and dangerous and, if so, what treatment disposition should be ordered by the mental health board. The board may order further discovery at its discretion. The county attorney shall have a reciprocal right to discover items and information comparable to those first discovered by the subject. The county court and district court shall have the power to rule on objections to discovery in matters which are not self-activating. The right of appeal from denial of discovery shall be at the time of the conclusion of the mental health board hearing.

Source: Laws 1976, LB 806, § 63; Laws 1981, LB 95, § 20; R.S.1943, (1999), § 83-1053; Laws 2004, LB 1083, § 69. Operative date July 1, 2004.

71-950 Continuances; liberally granted.

Continuances shall be liberally granted at the request of the subject. Continuances may be granted to permit the subject to obtain voluntary treatment at a private facility.

Source: Laws 1976, LB 806, § 64; Laws 1985, LB 252, § 6; R.S.1943, (1999), § 83-1054; Laws 2004, LB 1083, § 70. Operative date July 1, 2004.

71-951 Mental health board hearings; closed to public; exception; where conducted.

All mental health board hearings under the Nebraska Mental Health Commitment Act shall be closed to the public except at the request of the subject and shall be held in a courtroom or at any convenient and suitable place designated by the mental health board. The board shall have the right to conduct the proceeding where the subject is currently residing if the subject is unable to travel.

Source: Laws 1976, LB 806, § 65; Laws 2000, LB 884, § 15; R.S.Supp.,2002, § 83-1055; Laws 2004, LB 1083, § 71. Operative date July 1, 2004.

71-952 Subject's rights; appear in person and testify in own behalf; present witnesses and evidence.

A subject shall appear personally and be afforded the opportunity to testify in his or her own behalf and to present witnesses and tangible evidence in defending against the petition at the hearing.

Source: Laws 1976, LB 806, § 66; Laws 1981, LB 95, § 21; R.S.1943, (1999), § 83-1056; Laws 2004, LB 1083, § 72. Operative date July 1, 2004.

71-953 Subject's rights; compulsory process to obtain testimony of witnesses.

A subject shall be entitled to compulsory process to obtain the testimony of witnesses in his or her favor.

Source: Laws 1976, LB 806, § 67; R.S.1943, (1999), § 83-1057; Laws 2004, LB 1083, § 73. Operative date July 1, 2004.

71-954 Subject's rights; confront and cross-examine adverse witnesses and evidence.

A subject shall have the right at a hearing held under the Nebraska Mental Health Commitment Act to confront and cross-examine adverse witnesses and evidence equivalent to the rights of confrontation granted by Amendments VI and XIV of the United States Constitution and Article I, section 11, of the Constitution of Nebraska.

Source: Laws 1976, LB 806, § 68; Laws 1981, LB 95, § 22; Laws 2000, LB 884, § 16; R.S.Supp.,2002, § 83-1058; Laws 2004, LB 1083, § 74. Operative date July 1, 2004.

71-955 Hearings; rules of evidence applicable.

The rules of evidence applicable in civil proceedings shall apply at all hearings held under the Nebraska Mental Health Commitment Act. In no event shall evidence be considered which is inadmissible in criminal proceedings.

Source: Laws 1976, LB 806, § 69; Laws 1981, LB 95, § 23; Laws 2000, LB 884, § 17; R.S.Supp.,2002, § 83-1059; Laws 2004, LB 1083, § 75. Operative date July 1, 2004.

Annotations:

The transcript of the proceeding before a mental health board may not be treated as evidence before the board, the district court, or this court unless the facts in the transcript are offered as evidence, are not objected to, and are received by the trier of fact. In re Interest of Kinnebrew, 224 Neb. 885, 402 N.W.2d 264 (1987).

This statute makes the general rules of evidence applicable to proceedings under the Mental Health Commitment Act. In re Interest of Blythman, 208 Neb. 51, 302 N.W.2d 666 (1981).

This section does not mandate Miranda-type warnings precede a psychiatric interview by a doctor. Kraemer v. Mental Health Board of the State of Nebraska, 199 Neb. 784, 261 N.W.2d 626 (1978).

71-956 Subject's rights; written statements; contents.

A subject shall be entitled to written statements by the mental health board as to the evidence relied on and reasons (1) for finding clear and convincing evidence at the subject's hearing that he or she is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm described in section 71-908 and (2) for choosing the particular treatment specified by its order of final disposition. The mental health board shall make similar written findings when it orders a subject held in custody rather than released on conditions pending hearings to determine whether he or she is mentally ill and dangerous in need of treatment ordered by the mental health board or pending the entry of an order of final disposition under section 71-925.

Source: Laws 1976, LB 806, § 70; Laws 1981, LB 95, § 24; R.S.1943, (1999), § 83-1060; Laws 2004, LB 1083, § 76. Operative date July 1, 2004.

71-957 Proceedings shall be of record; reporter; expenses and fees.

All proceedings held under the Nebraska Mental Health Commitment Act shall be of record, and all oral proceedings shall be reported verbatim by either a qualified shorthand reporter or by tape-recording equipment equivalent in quality to that required in county courts by section 25-2732. The written findings of the mental health board shall be part of the subject's records and shall be available to the parties in the case and to the treatment facility where the subject is receiving treatment pursuant to a commitment order of the mental health board under section 71-925. Any qualified shorthand reporter who reports proceedings presided over by a board or otherwise than in his or her capacity as an official district court stenographic reporter shall apply to the court for reasonable expenses and fees for services performed in such hearings. The court shall fix reasonable expenses and fees, and the county board shall allow payment to the reporter in the full amount fixed by the court.

Source: Laws 1976, LB 806, § 71; Laws 2000, LB 884, § 18; R.S.Supp.,2002, § 83-1061; Laws 2004, LB 1083, § 77. Operative date July 1, 2004.

71-958 Qualified mental health professional; provide medical treatment to subject; when.

Any qualified mental health professional, upon being authorized by the administrator of the treatment facility having custody of the subject, may provide appropriate medical treatment for the subject while in custody, except that a subject shall not be subjected to such quantities of medication or other treatment within such period of time prior to any hearing held under the Nebraska Mental Health Commitment Act as will substantially impair his or her ability to assist in his or her defense at such hearing.

Source: Laws 1976, LB 806, § 72; Laws 2000, LB 884, § 19; R.S.Supp.,2002, § 83-1062; Laws 2004, LB 1083, § 78. Operative date July 1, 2004.

Cross Reference:

Mistreatment of mentally ill person, penalty, see section 83-356.

71-959 Subject in custody or receiving treatment; rights; enumerated.

A subject in custody or receiving treatment under the Nebraska Mental Health Commitment Act has the right:

(1) To be considered legally competent for all purposes unless he or she has been declared legally incompetent. The mental health board shall not have the power to declare an individual incompetent;

(2) To receive prompt and adequate evaluation and treatment for mental illness and physical ailments and to participate in his or her treatment planning activities to the extent determined to be appropriate by the mental health professional in charge of the subject's treatment;

(3) To refuse treatment medication, except (a) in an emergency, such treatment medication as is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself, or others or (b) following a hearing and order of a mental health board, such treatment medication as will substantially improve his or her mental illness;

(4) To communicate freely with any other person by sealed mail, personal visitation, and private telephone conversations;

(5) To have reasonably private living conditions, including private storage space for personal belongings;

(6) To engage or refuse to engage in religious worship and political activity;

(7) To be compensated for his or her labor in accordance with the federal Fair Labor Standards Act, 29 U.S.C. 206, as such section existed on January 1, 2004;

(8) To have access to a patient grievance procedure; and

(9) To file, either personally or by counsel, petitions or applications for writs of habeas corpus for the purpose of challenging the legality of his or her custody or treatment.

Source: Laws 1976, LB 806, § 76; Laws 2000, LB 884, § 21; R.S.Supp.,2002, § 83-1066; Laws 2004, LB 1083, § 79. Operative date July 1, 2004.

71-960 Subject; waive rights; manner.

A subject may waive any of the proceedings or rights incident to proceedings granted him or her under the Nebraska Mental Health Commitment Act by failing to request any right expressly required to be requested but, in the case of all other such rights, only if the record reflects that such waiver was made personally, intelligently, knowingly, understandingly, and voluntarily by the subject and such subject's legal guardian or conservator, if any. Such rights may otherwise be denied only by a mental health board or court order for good cause shown after notice to the subject, the subject's counsel, and such subject's guardian or conservator, if any, and an opportunity to be heard. If the mental health board determines that the subject is not able to waive his or her rights under this section, it shall be up to the discretion of the subject's counsel to exercise such rights. When the subject is not represented by counsel, the rights may not be waived.

Source: Laws 1976, LB 806, § 74; Laws 1996, LB 1155, § 109; Laws 2000, LB 884, § 20; R.S.Supp.,2002, § 83-1064; Laws 2004, LB 1083, § 80. Operative date July 1, 2004.

71-961 Subject's records; confidential; exceptions.

(1) All records kept on any subject shall remain confidential except as otherwise provided by law. Such records shall be accessible to (a) the subject, except as otherwise provided in subsection (2) of this section, (b) the subject's legal counsel, (c) the subject's guardian or conservator, if any, (d) the mental health board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject, (g) agents or employees of the Department of Health and Human Services Regulation and Licensure upon delivery of a subpoena from the department in connection with a licensing or licensure investigation by the department, or (h) the Nebraska State Patrol or the Department of Health and Human Services pursuant to section 69-2409.01.

(2) Upon application by the county attorney or by the administrator of the treatment facility where the subject is in custody and upon a showing of good cause therefore, a judge of the district court of the county where the mental health board proceedings were held or of the county where the treatment facility is located may order that the records not be made available to the subject if, in the judgment of the court, the availability of such records to the subject will adversely affect his or her mental illness and the treatment thereof.

(3) When a subject is absent without authorization from a treatment facility or program described in section 71-939 and is considered to be dangerous to others, the subject's name and description and a statement that the subject is believed to be considered dangerous to others may be disclosed in order to aid in the subject's apprehension and to warn the public of such danger.

Source: Laws 1976, LB 806, § 78; Laws 1996, LB 1055, § 17; Laws 1996, LB 1155, § 111; Laws 1997, LB 307, § 230; R.S.1943, (1999), § 83-1068; Laws 2004, LB 1083, § 81. Operative date July 1, 2004.

71-962 Violations; penalty.

Any person who willfully (1) files or causes to be filed a certificate or petition under the Nebraska Mental Health Commitment Act, knowing any of the allegations thereof to be false, (2) deprives a subject of any of the rights granted the subject by the act or section 83-390, or (3) breaches the confidentiality of records required by section 71-961 shall be guilty of a Class II misdemeanor in addition to any civil liability which he or she may incur for such acts.

Source: Laws 1976, LB 806, § 79; Laws 1977, LB 41, § 63; Laws 2000, LB 884, § 22; R.S.Supp.,2002, § 83-1069; Laws 2004, LB 1083, § 82. Operative date July 1, 2004.

APPENDIX B

Snapshots of Nebraska MH and SA Service Definitions

Nebraska Behavioral Health System (NBHS)
SERVICE DEFINITIONS

(Services **Funded** through the Division and the Regions)

NOTE: All consumers referred to outpatient community mental health services MUST be medically and psychiatrically stable prior to admission.

Mental Health Services

Mental Health Emergency

24-Hour Crisis Line – Telephone access 24-hours/day, 7 days a week to staff trained in Mental Health support with access to Mental Health Professionals.

Mobile Crisis Response Teams – A two-person team offers on-site services assessment and crisis stabilization for individuals experiencing a mental health crisis; includes access to trained mental health staff, 24-hours/7days per week to provide interventions and/or screenings.

Crisis Respite – 24-hour short-term residential care typically for no more than 3 days for individuals with a severe and persistent mental illness needing supervised assistance to stabilize on their medications or get back on their medications.

Emergency Community Support – Aftercare service for individuals who have received Emergency Services; includes service identification, ensure arrangement and attendance at services, coordination of a care plan, provide or arrange for transportation, assist with housing, and direct support for teaching activities of daily living to keep someone out of the hospital. This service may begin until longer-term community support is available in the home community. The emergency community support averages no more than 120 days.

Crisis MH Assessment (see Crisis Center) – A thorough mental health assessment/evaluation completed by a psychiatrist for persons admitted to a Crisis Center on an EPC involuntary hold to determine mental illness diagnosis, dangerousness, and recommended service level. An evaluation for the Emergency Protective Custody (EPC) hold is completed within 36 hours to determine if further action should be taken.

Crisis Center (EPC) – 24-hour medical facility that can provide emergency care to stabilize a person on an EPC hold who is alleged to be mentally ill and dangerousness and/or substance dependent and dangerousness.. The county attorney makes a decision within 72 hours whether to request a hearing to involuntarily require someone to receive appropriate mental health and/or substance abuse services. An EPC hold can be dropped after the evaluation if no mental illness or substance dependency is found, or if the person agrees to voluntarily seek treatment. A commitment hearing must be held within 7 days of admission.

Mental Health Residential

(Step down after commitments)

Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.

Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with severe and persistent mental illness and substance dependence. Includes medication management and psychosocial rehab as well as treatment for stabilization and recovery. Substance abuse and mental health professionals staff the service. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.

Mental Health Non-Residential

Assertive Community Treatment – Self-contained ten-member clinical team which assumes responsibility for directly providing comprehensive treatment, rehabilitation and support services to eligible consumers with severe and persistent mental illness. Often termed a “hospital without walls”, it allows for a team of professionals to be responsible for whatever it takes to keep someone out of the hospital. A team leader, psychiatrist, nurses, licensed mental health practitioner, certified substance abuse counselor, vocational specialist, peer specialist and other mental health professionals are full time members of the team. Because of the lack of psychiatrists and other clinically trained professionals on the team, this team approach to service provision has limited applicability in rural areas. Duration of this service is as needed to achieve stability in the functional deficit areas.

Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days..

Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.

Vocational Rehabilitation – Job coaching and supported employment funded through the Division of Vocational Rehabilitation with matching funds from the NBHS system. Services are provided to persons with severe and persistent mental illness.

Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level.

Psychological Testing – Psychological and diagnostic tests completed by a licensed, clinical psychologist.

Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.

Vocational Support – Ongoing support for persons with severe and persistent mental illness after they have secured long term employment. The support activities general take place off the job site, but can include assistance in learning job duties, problem solving and other job functions in order for individual to maintain gainful employment. Length of service depends on individual consumer need but is usually not longer than 6-24 months.

Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition “drop-in” center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be 3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years.

Care Monitoring (MH) -- Ongoing support case management service for persons who no longer need the active rehabilitation service of Community Support. Length of service depends on individual consumer need with documented client contact of no more than one time per month in person or by phone.

Nebraska Behavioral Health System (NBHS)
SERVICE DEFINITIONS
(Services Funded through the Division and the Regions)

*NOTE: All consumers referred to outpatient community substance abuse services **MUST** be medically and psychiatrically stable prior to admission.*

Substance Abuse Services

Substance Abuse Emergency

24 Hour Crisis Line - Telephone access 24-hours/day, 7 days a week to staff trained in Substance Abuse support with access to Substance Abuse certified professionals.

Social Detoxification / Civil Protective Custody (CPC) – Provides intervention in substance abuse emergencies on a 24-hour/day basis for acutely intoxicated individuals to restore from intoxicated state. Provides residential setting with staff present for observation, monitoring of vital signs, administration of fluids, provision for rest and substance abuse education, counseling and referral. Length of service varies depending on individual needs but is usually not longer than 2-5 days. CPC is a 24-hour legal hold that law enforcement can use to provide safety for the intoxicated person presented a danger to him/herself and/or others. The Social Detox facility may have 1-4 locked rooms available for a CPC involuntary hold to provide protection and detoxification services.

Emergency Community Support – Aftercare service for individuals who have received Emergency Services that includes service identification, ensure arrangement and attendance at services, coordination of a care plan, provide or arrange for transportation, arrange for housing and direct support for teaching activities of daily living to keep someone out of high intensity residential services. This service may begin until longer-term community support is available in the home community. The emergency community support averages no more than 120 days.

Crisis SA Assessment (see Crisis Center) – A thorough substance abuse assessment/evaluation completed by a Certified Alcohol and Drug Abuse Counselor (CADAC) or other clinician within the scope of practice for persons admitted to a Crisis Center on an EPC involuntary hold to determine substance abuse diagnosis, dangerousness, and recommended service level. An evaluation for the Emergency Protective Custody (EPC) hold is completed within 36 hours to determine if further action should be taken.

Crisis Center (EPC) – 24-hour medical facility that can provide emergency care to stabilize a person on an EPC hold who is alleged to be mentally ill and dangerousness and/or substance dependent and dangerousness. The county attorney makes a decision within 72 hours whether

to request a hearing to involuntarily require someone to receive appropriate mental health and/or substance abuse services. An EPC hold can be dropped after the evaluation if no mental illness or substance dependency is found, or if the person agrees to voluntarily seek treatment. A commitment hearing must be held within 7 days of admission.

Substance Abuse Residential

Intermediate Residential -- Facility based service for chronic substance dependent persons who are at a high risk for relapse and/or a potential harm to self and others; these persons have significant deficits in ability to perform activities of daily living and/or cognitive deficits. Service provides significant staff support and addresses individual deficits at a moderately intensive level over a longer, sustained time. Length of service varies depending on individual needs but is not longer than 12-24 months.

Short Term Residential -- 24-hour, non-medical residential facility in the community for persons with primary substance dependence, an entrenched dependency pattern of usage and an inability to remain drug-free outside of 24 hour care. **Persons admitted must be medically and psychiatrically stable.** Provides highly structured, intensive, comprehensive addiction recovery services including individual and group therapy and counseling, limited medications services, and relapse prevention. Length of service varies depending on individual needs but is not longer than 15-30 days. Service formerly termed “inpatient” but can be successfully provided in the community not in a hospital.

Therapeutic Community -- 24-hour, non-medical residential facility in the community for persons with primary substance dependence. Persons are medically and psychiatrically stable. These programs provide psychosocial skill building through a longer term, highly structured set of peer oriented treatment activities which incorporate a series of defined phases. Services include a mixture of individual and group counseling/therapy, relapse prevention, educational, vocational and skill building activities. Length of service varies depending on individual needs but is not longer than 12-18 months.

Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with primary substance dependence and a severe and persistent mental illness. Includes addiction recovery counseling and activities as well as medication management and education, and psychosocial rehabilitation services for the most severely mentally ill. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.

Halfway House -- A transitional residential treatment facility in the community for adults seeking to re-integrate into the community, generally after primary treatment has been completed.

Programs provide a structured supportive living environment, a set of activities designed to develop recovery living and relapse prevention skills and assists clients in maintaining or accessing employment as needed. The services are designed to develop the living skills necessary for an independent life free from substance abuse outside of a residential treatment program. Length of service varies depending on individual needs but is not longer than 90 days to 6 months.

Substance Abuse Non-Residential

Partial Care -- Specialized, facility based day program for persons with substance abuse/dependence problems. Provides intensive necessary services with medical back up in day programming including assessment, individual, family and group therapy and medication services as prescribed by a multidisciplinary team. A typical day includes up to 8-10 hours of programming. Length of service varies depending on individual needs but is usually not longer than 5-6 weeks.

Intensive Outpatient – Provides group focused non-residential treatment services for substance abuse/dependent individuals. Programming is centered on group counseling services and includes lectures and other didactic education. Services must include a minimum of 10 hours per week with at least 8 of those hours in group therapy and 2 in individual therapy. The therapy sessions take place a minimum of 3 to 5 times per week. Length of service varies depending on individual needs but is usually not longer than 6 weeks.

Community Support – 24 hour, 7 day/week availability of substance abuse support for persons with a substance dependency with the purpose to provide consumer advocacy, ensures continuity of care, support in time of crisis, provide direct procedural and recovery skill training, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with substance use disorders; a combination of case management, service coordination, and direct residential and community service support. Length of service varies depending on individual needs but is usually not longer than 6 months – 12 months.

Outpatient/Assessment – Assessment, diagnosis and counseling for a variety of substance use disorders which disrupt an individual's life; treatment to change behavior, modify thought patterns, cope with problems, improve functioning, and may include coordination to other services to achieve successful outcomes and prevent relapse. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Prevention counseling and family counseling are included in this service level.

Methadone Maintenance – Administration of methadone medication to enable an opiate addicted person to be free of heroin. Methadone replacement for heroin is a lifetime maintenance program. Counseling therapy interventions are included in the program. Administration of methadone medication occurs over several years.

Care Monitoring (SA) -- Ongoing support case management service for persons who no longer need the active rehabilitation service of Community Support. Length of service depends on individual consumer need with documented client contact of no more than one time per month in person or by phone.

APPENDIX C

Glossary of General Terms

GLOSSARY OF GENERAL TERMS
for
Nebraska Behavioral Health System (NBHS)
(Services funded through the Office and the Regions)

NOTE: All consumers referred to outpatient community behavioral health services in Nebraska MUST be medically and psychiatrically stable prior to admission.

Substance Use -- The taking of any substance whether alcohol, drugs and/or tobacco; includes both legal and illegal substances.

Substance Abuse – A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. The criterion does not include tolerance, withdrawal, or a pattern of compulsive use.

Substance Dependent (CD) – A maladaptive pattern of repeated substance use that usually results in tolerance, withdrawal, and compulsive substance-taking behavior. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. Term used interchangeably with chemical dependence.

Severe Emotional Disturbance (SED) -- Serious Emotional Disturbance is an Axis I diagnosable mental disorder in children and adolescents that is persistent and results in functional impairment in two or more life domains.

Mental Illness (MI) – Persons with mental illness have a normal range of intelligence, but also have a brain disease. The most common brain diseases fall within the category of major mental illness and are sometimes referred to as severe and persistent mental illness (SPMI). The diagnoses for SPMI include schizophrenia or schizoaffective, bi-polar, and major depression. These diseases are controllable within limitations, but not curable.

Developmental Disability (DD) – A person with a developmental disability has an Intelligence Quotient (IQ) of 69 or lower, is considered mentally retarded (MR). The intelligence level does not change during the person's lifetime. The service system serving persons with a developmental disability is often referred to as the "DD" system. Adults or children with development disabilities are NOT considered mentally ill.

Dual Disorder – An *adult* with a primary severe and persistent mental illness **AND** a primary substance dependency disorder. An *adolescent* with a primary serious emotional disturbance **AND** a primary substance dependency (or diagnosed entrenched dependency pattern).

Dual Disorder Residential Treatment – Dual Disorder services provide primary integrated treatment simultaneously to persons with an Axis I substance dependency **AND** an Axis I major mental illness. Clients served exhibit more unstable or disabling co-occurring substance dependence and serious and persistent mental illness disorders. The typical client is unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in addictions treatment. Providers of Dual Disorder Treatment programs demonstrate a philosophy of integrate treatment in treatment plans, program plans, staffing, and services provided. Both disorders are treated as equally primary. Appropriate licensed and certified staff including staff with addiction certification is required to provide treatment.

Dual Enhanced Non-Residential Treatment – A service for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers of these treatment services may elect to enhance their primary service to address the client's other relatively

stable diagnostic or sub--diagnostic co-occurring disorder. The primary focus of such programs is mental health or addictions treatment rather than dual diagnosis concerns and is not a integrated dual disorder residential treatment.

Committed or Court Ordered – When the Mental Health Board (adults) or a Judge (adolescents) upon recommendation from an appropriately licensed or certified professional finds that the individual has a mental illness and is dangerous, OR has a substance dependency and is dangerous, they will commit or court order to involuntary treatment. A person under *committed or court ordered* (involuntary) status must comply with the commitment or court order, no matter where they are committed or ordered to inpatient or a community based provider).

Admitted – A person can be *admitted* to any service whether that admission is voluntary, or involuntary through a commitment. Persons admitted to a service are determined to meet admission criteria to ensure the service is appropriate to meet their specific needs.

Voluntary – The ability of any person to chose a service they would like to participate in.

Involuntary – A person is placed in a service and loses certain rights until the involuntary order is lifted.

Division of Behavioral Health – A division within the Department of Health and Human Services that oversees the administration of services for mental health, substance abuse, and gambling. This includes (1) community based services under the management of the Division of Behavioral Health Services and (2) state operated services provided at the State Regional Centers.

NBHS – Nebraska Behavioral Health System is the publicly funded community based mental health, substance abuse service system in Nebraska administered by the Division of Behavioral Health Services with funding going through the Mental Health and Substance Abuse Regions to provider networks.

Regional Governing Boards – The public mental health and substance abuse community service system is divided into six geographic regions. A county commissioner from each county in the region serves on a governing board to plan, develop, and implement services, and hires staff to fulfill the administrative duties. Region 1 includes 11 counties with the Regional Office in Scottsbluff. Region 2 includes 17 counties with the Regional Office in North Platte. Region 3 includes 22 counties with the Regional Office in Kearney. Region 4 includes 22 counties with the Regional Office in Norfolk. Region 5 includes 16 counties with the Regional Office in Lincoln. Region 6 includes 6 counties with the Regional Office in Omaha.

CPC – Civil Protective Custody. An involuntary hold that law enforcement can use to hold an intoxicated adult (age 19 and over) for 24 hours in a social detoxification facility with the capability of locking the doors.

EPC – Emergency Protective Custody. An involuntary hold that law enforcement can use to hold an adult (age 19 and over) they determine to be mentally ill and dangerous, or substance dependent and dangerous.

Crisis Center -- Once an involuntary hold is placed on an adult, the holding facility has 72 hours to have a licensed professional forward an evaluation to the county attorney to determine if the person is mentally ill or substance dependent. Crisis centers are medical facilities that are funded through the Regions to serve adults with a mental illness and/or substance abuse crisis in the counties of that region as part of the commitment process.

Mental Health Board -- If the evaluation at a Crisis Center finds that there is a mental illness and/or chemical dependency and the County Attorney agrees, a Mental Health Board hearing is set for adults within seven days of the EPC hold to have a neutral board of three individuals determine if there is mental illness, or substance dependency and if there is dangerousness.

Regional Center – A state operated 24-hour psychiatric facility for persons with mental illness. The state currently operates two Regional Centers: Lincoln Regional Center and Norfolk Regional Center. Within the NBHS, the Regional Centers provide inpatient and secure residential services for adults of the state. Hastings Regional Center is now primarily a SubAcute (40) bed residential facility serving all regions and has an adolescent alcohol/drug treatment program for male youth referred from YRTC-Kearney. Lincoln Regional Center primarily serves residents from Region 5. Norfolk Regional Center primarily serves residents from all regions.

Medicaid – Federal and State funding available to persons who meet Medicaid eligibility criteria: children, adults with children who meet poverty guidelines, certain adults with a disability, and the elderly. Medicaid is a financing system, not a service system.

Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- Antisocial personality disorder represents a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are central features.





There is also a failure to conform to social norms with respect to lawful behaviors, impulsivity, irritability and aggressiveness, reckless disregard for the safety of others, consistent irresponsibility and a lack of remorse for their actions.
- Schizotypal personality disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as cognitive or perceptual distortions and eccentricities of behavior, beginning in early adulthood. Individuals with schizotypal personality disorder often have ideas of reference, odd beliefs, odd thinking, suspiciousness, odd behavior, lack of close friends, and excessive social anxiety.

Paraphilias feature recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors, generally involving non-human objects, suffering or humiliation of oneself or one's partner, children, or other non-consenting persons, that occurs over a period of at least 6 months.

APPENDIX D

MH and SA Service Matrix of Public Safety and Service Intensity

MATRIX OF MENTAL HEALTH SERVICES by Level of Public Safety, External Structure Needs, and Symptomology

Commitment Act Designation of Commitment	L e a s t R e s t r i c t i v e M o s t	Level of Care	Service	Risk of Relapse	Risk of Harm to Self/Others	Need for External Professional Structure	Symptomology
OUTPATIENT Commitments (to community providers)	 	Non-Residential LOC Level 5	Vocational Support	Low	Low	Low (Follow along support for for client with full time job)	Mild to moderate (GAF 41-70)
		Level 5	Medication Management	Moderate to low	Low to moderate	Moderate to low (Physician med checks in addition to other srvc's; or quarterly, when stable)	Mild to severe (GAF 21-70)
		Level 4	Outpatient Therapy	Low to moderate	Low to moderate	Low (Up to 10 therapy sessions over several weeks)	Mild to moderate (GAF 31-70)
		Level 3	Day Rehabilitation	Low to moderate	Low to moderate	Moderate (3-5 hours program/day; 2-5 days/week per need)	Moderate to severe (GAF 31-60) Two or more functional limitations
		Level 3	Community Support	Moderate	Moderate	Moderate (Used in combination with other non- residential srvc's; intensive case management with direct skill training)	Moderate (GAF 31-60) Two or more functional limitations
		Level 2	Intensive Outpatient	Moderate	Moderate	Moderate (Minimum 10 hours group & individual therapy/week)	Moderate to severe (GAF 31-50) One or more functional limitations
		Level 1	Day Treatment	High to moderate	High to moderate	High (Requires medication mgmt; more than 6 hours of structured programming required per day)	Moderate to severe (GAF 31-50) Significant interference in one functional area
		Residential LOC Transitional	Psych Residential Rehabilitation	High to moderate	Moderate	Moderate (Active rehab to acquire living skills & move to independence; 24 hour non-institutional community residential)	Moderate (GAF 31-60) (Two or more functional limitations) (Stable psychiatric condition)
INPATIENT Commitments (to Regional Centers or hospitals contracted with Regions)	 	Intermediate	Intermediate Residential	High	High to moderate	High to moderate (Expectation of slower progress toward change/rehab)	High to moderate (Stable psych condition with significant cognitive deficits & two functional limitations)
		Inpatient to HHSS					
			Secure Subacute	High (psychiatrically unstable) (medically stable)	High	High (Highly secure, 24 hour supervision; seclusion/restraint available)	Severe (Psychiatrically unstable with GAF 31-41) (At least two functional limitations)
			Acute Inpatient	High (medically unstable)	High	High (Highly acute; daily treatment adjustment; highly secure w/medical)	Severe (Psychiatrically unstable) (At least two functional limitations)

Symptomology Terms

- Critical Symptom Factors (GAF scores): Acute: 0-19; Severe: 20-30; Moderate: 31-60; Low: 61-70.
- Functional Areas: social, vocational, educational, activities of daily living/life skills (ie, budgeting, cooking, etc), interpersonal skills, housing, legal, family/marital, employment, crisis/relapse, medication management, substance abuse, resource acquisition.

MATRIX OF SUBSTANCE ABUSE SERVICES by Level of Public Safety, External Structure Needs, and Symptomology

Commitment Act Designation of Commitment	L e a s t R e s t r i c t i v e ↑ ↓ M o s t R e s t r i c t i v e	Level of Care	Service	Risk of Relapse	Risk of Harm to Self/Others	Need for External Professional Structure	Symptomology
OUTPATIENT Commitments (to community providers)		Non Residential LOC					
		Level 4	Outpatient Therapy	Low to moderate	Low to moderate	Low (Up to 10 therapy sessions over several weeks)	Mild to moderate (GAF 31-70)
		Level 3	Community Support	Moderate	Low to moderate	Moderate (Used in combination with other non- non-residential srvc's, especially Intensive Outpatient; intensive case management with direct skill training)	Moderate (GAF 31-60) (Three or more problem areas) (Substance dependent)
		Level 2	Intensive Outpatient	Moderate to high	Low to moderate	Moderate (Minimum 10 hours group & individual therapy/week) (Combines well w/Community Support)	Moderate to high (GAF 31-50) (Unstable substance abuse problem)
		Level 1	Partial Care	High	Moderate	High to moderate (Daily non-res structure to prevent immediate relapse; more than 6 hours structured programming required/day)	Moderate to severe (GAF 31-50) (Unstable substance abuse problem) (Significant deficits in two problem areas)
		Residential LOC					
		Transitional	Halfway House	High	Moderate	Moderate (Support services, opportunity to work while in the service and build coping skills)	Moderate (GAF 41-60) (Two or more problem areas) (Stable psychiatric condition)
			Therapeutic Community	High	Moderate to high	Moderate to high (Expectation of slower progress toward change/rehab)	Moderate to Severe (GAF 31-60) (Two or more problem areas; generally w/a co-occurring personality disorder)
			Short Term Residential	High	Moderate to high	Moderate to high (21-30 day short term comprehensive service with 24 hour supervision) (Community Support effective at discharge)	Moderate to Severe (GAF 31-60) (Two or more problem areas)
		Intermediate	Intermediate Residential	High	Moderate to high	Moderate to high (Expectation of slower progress toward change/rehab; prior history of multiple treatment failures)	Moderate to High (Stable condition with significant cognitive deficits & at least two problem areas)

Symptomology Terms { Critical Symptom Factors (GAF scores): Acute: 0-19; Severe: 20-30; Moderate: 31-60; Low: 61-70.
Problem Areas: relapse prevention, interpersonal skills, life skills, housing, legal, medical, family/marital, employment, vocational; educational, toxicology, emergency/relapse, social, medication management, mental health, substance abuse, resource acquisition.

APPENDIX E

Regional Contact for Local Services and Providers

**Region Approved Providers
Mental Health Services
Funded by Division of Behavioral Health Services FY 06
Nov-05**

Region	Provider	MH Approved Service
1	Panhandle Mental Health Center 4110 Avenue D Scottsbluff, NE 69361	24 Hour Crisis Phone Crisis Assessment/Evaluation - MH Crisis Response Teams Crisis Respite - MH Emergency Community Support - MH or SA Community Support - MH Outpatient Therapy - MH Medication Management - MH Youth Outpatient Therapy - MH Youth Day Treatment - MH
1	Panhandle Mental Health Center 212 Box Butte Ave Alliance NE 69301	Outpatient Therapy - MH Medication Management - MH
1	Panhandle Mental Health Center 2246 Jackson Avenue Sidney NE 69162	Medication Management - MH
1	Region 1 4110 Avenue D Scottsbluff, NE 69361	Youth Professional Partner - MH Youth Professional Partner School Wrap - MH
1	Lutheran Family Services 906 N Street Gering NE 69341	Outpatient Therapy - MH
1	Lutheran Family Services 651 West 4th Chadron NE 69337	Outpatient Therapy - MH
1	Lutheran Family Services 921 23rd Street Sidney NE 69162	Outpatient Therapy - MH
1	NPERP PO Box 1299 Chadron NE 69337	Crisis Response Teams Emergency Community Support - MH or SA
1	Regional West Medical Center 4021 Avenue "B"	EPC Services (Involuntary) Acute Inpatient

Scottsbluff, NE 69361	Subacute Inpatient Dual Residential - SPMI & CD
1 Box Butte General Hospital PO Box 810 Alliance, NE 69301	Crisis Assessment/Evaluation - MH Crisis Response Teams Emergency Community Support - MH or SA
1 Chadron Community Hospital 821 Morehead Street Chadron NE, 69337	Crisis Assessment/Evaluation - MH
1 Cirrus House 1509 1st Avenue PO Box 442 Scottsbluff, NE 69361	Community Support - MH Day Rehabilitation - MH Vocational Rehabilitation Vocational Support Day Support - MH
1 Western Community Health Resources PO Box 857 Chadron NE 69337	Community Support - MH
2 Region II Human Services PO Box 1208 North Platte, NE 69103	Community Support - MH Day Rehabilitation - MH Assessment/Evaluation - MH Psychological Testing Outpatient therapy - MH Outpatient therapy - SPMI & CD Medication Management - MH Day Support - MH Youth Professional Partner - MH Youth Therapeutic Consultation Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Outpatient Therapy - Dual SED & CD Medication Management - MH
2 Region 2 Human Services 1012 West Third McCook NE 69001	Community Support - MH Assessment/Evaluation - MH Outpatient Therapy - MH Psychological Testing Outpatient Therapy - Dual (SPMI & CD) Medication Management - MH Day Rehabilitation - MH Day Support - MH
2 Region 2 Human Services 307 E 5th Lexington NE 68850	Community Support - MH Assessment/Evaluation - MH Outpatient Therapy - MH Psychological Testing Outpatient Therapy - Dual (SPMI & CD) Medication Management - MH

2	Region 2 Human Services 401 W 1st Ogallala NE 68153	Community Support - MH Assessment/Evaluation - MH Outpatient Therapy - MH Psychological Testing Outpatient Therapy - Dual (SPMI & CD) Medication Management - MH
2	Region 2 Human Services 114 S Chestnut North Platte NE 69101	Community Support - MH Day Rehabilitation - MH Day Support - MH
2	CenterPointe 2633 P Street Lincoln NE 68503	Dual Residential - SPMI & CD
2	Great Plains Medical Center 601 West Leota Street PO Box 1167 North Platte, NE 69103	EPC Services (Involuntary) Acute Inpatient Subacute Inpatient Youth Crisis Inpatient - MH
2	Goodwill Industries 1804 South Eddy Grand Island NE 68802	Community Support - MH Vocational Rehabilitation
2	Hotel Pawnee 221 East Fifth North Platte, NE 69101	Crisis Respite - MH Community Support - MH
2	Liberty House 420 West 4th Street North Platte NE 69101	Crisis Respite - MH
2	Richard Young Hospital 4600 17th Avenue, PO Box 1750 Kearney NE 68848	24 Hour Crisis Phone Crisis Response Teams Emergency Community Support - MH or SA EPC Services (Involuntary) Acute Inpatient Subacute Inpatient Youth Crisis Inpatient - MH
3	Region III Behavioral Health Services 4009 6th Avenue, #65 PO Box 2555 Kearney, NE 68848	Emergency Community Support - MH or SA Youth Professional Partner - MH
3	Center for Psychological Services 1709 W. 39th Street, Suite 1 Kearney, NE 68845	24 Hour Crisis Phone (Regionwide) Crisis Response Teams Youth Outpatient Therapy - MH
3	Catholic Charities 3020 18th Street Columbus NE 68601	Dual Residential - SPMI & CD

3	Goodwill Industries 1804 South Eddy PO Box 1863 Grand Island NE 68802	Emergency Community Support - MH or SA Community Support - MH Day Rehabilitation - MH Vocational Rehabilitation - MH Vocational Support - MH Day Support - MH
3	Mary Lanning Hospital 715 North St. Joseph Avenue Hastings, NE 68901	Emergency Community Support - MH or SA EPC Services (Involuntary) Acute Inpatient Medication Management - MH
3	Mid-Plains 914 Baumann Drive PO Box 1763 Grand Island, NE 68802-1763	Crisis Response Teams Urgent Outpatient Therapy - MH or SA (LADC) Crisis Stabilization & Treatment (Voluntary) Psychological Testing Outpatient Therapy - MH Outpatient Therapy - Dual (SPMI & CD) Medication Management - MH Youth Day Treatment - MH Youth Home Based or Multisystemic Therapy Youth Outpatient Therapy - MH Youth Medication Management - MH Youth Therapeutic Consultation
3	Mid-Plains Box 34 Mason City NE 68855	Outpatient Therapy - MH Psychological Testing Outpatient Therapy - Dual (SPMI & CD)
3	Mid-Plains 1712 O Street Ord NE 68862	Outpatient Therapy - MH
3	Richard Young Hospital 4600 17th Avenue PO Box 1750 Kearney, NE 68848	Crisis Respite - MH EPC Services (Involuntary) Acute Inpatient Medication Management - MH Youth Crisis Inpatient - MH
3	South Central Behavioral Services 3810 Central Ave PO Box 1715 Kearney, NE 68848	Community Support - MH Outpatient Therapy - MH Psyc Residential Rehab - MH Day Rehabilitation - MH Vocational Support - MH Day Support - MH Youth Outpatient Therapy - MH
3	South Central Behavioral Services, Inc 724 S Burlington Hastings NE 68901	Day Support - MH Vocational Support - MH Day Rehabilitation - MH
3	South Central Behavioral Services, Inc 616 W 5th St	Outpatient Therapy - MH

Hastings NE 68901

- | | | |
|---|--|---|
| 3 | South Central Behavioral Services, Inc
701 4 th Ave Suite 7
Holdrege NE 68949 | Outpatient Therapy - MH |
| 3 | South Central Behavioral Services, Inc
510 East 10th
Superior NE 68978 | Outpatient Therapy - MH |
| 3 | South Central Behavioral Services, Inc
121 15 Ave
Franklin NE 68939 | Outpatient Therapy - MH |
| 3 | South Central Behavioral Services, Inc
1136 N Washington
Hastings NE 68901 | Psychological Residential - SPMI & CD |
| 4 | Behavioral Health Specialists, Inc.
600 So. 13th St.
Norfolk, NE 68701 | Crisis Response Teams
Urgent Assessment - MH or SA
Community Support - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |
| 4 | Catholic Charities of Columbus
3020 18Th Street, #17
Columbus, NE 68601 | Crisis Assessment/Evaluation - MH
Urgent Assessment/Evaluation - MH or SA
Crisis Stabilization & Treatment (Voluntary)
Community Support - MH
Crisis Respite - MH
Dual Residential - SPMI & CD
Psych Residential Rehab - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |
| 4 | Faith Regional Health Services
1500 Koenigstein Ave
Norfolk, NE 68701 | Crisis Assessment/Evaluation - MH
EPC Services (Involuntary)
Acute Inpatient
SubAcute Inpatient
Medication Management - MH |
| 4 | Heartland Counseling Services, Inc
917 W 21st Street
South Sioux City, NE 68776 | Emergency Community Support - MH or SA
Community Support - MH
Urgent Assessment/Evaluation - MH or SA
Outpatient Therapy - MH
Medication Management - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |

4	Heartland Solutions 318 E. Highway 20 PO Box 246 O'Neill NE 68763	Urgent Assessment/Evaluation - MH or SA Crisis Response Teams Emergency Community Support - MH or SA Community Support - MH Day Rehabilitation - MH Outpatient Therapy - MH Medication Management - MH Day Support - MH Youth Outpatient Therapy - MH Youth Medication Management - MH
4	Liberty Centre Services, Inc. 900 East Norfolk Ave Norfolk, NE 68701	Crisis Respite - MH Community Support - MH Psych Residential Rehab - MH Day Rehabilitation - MH Vocational Rehabilitation Vocational Support Day Support - MH
4	Professional Partner Program 206 Monroe Avenue Norfolk NE 68701 Region 4 Behavioral Health System 206 Monroe Avenue Norfolk NE 68701	Youth Professional Partner - MH Youth Professional Partner School Wrap - MH Emergency Community Support - MH or SA
4	Rainbow Center 3602 16th Street Columbus, NE 68601	Crisis Response Teams Crisis Respite - MH Community Support - MH Day Rehabilitation - MH Day Support - MH
4	R Way 219 Main Street Wayne, NE 68787	Crisis Respite - MH Community Support - MH Psych Residential Rehabilitation - MH Day Rehabilitation - MH
4	Well Link, Inc 305 North 9th Street, PO Box 1392 Norfolk NE 68702	Community Support - MH
5	Blue Valley Mental Health 1121 No 10th Street Beatrice, NE 68310	24 Hour Crisis Phone Crisis Response Teams Community Support - MH Outpatient Therapy - MH Medication Management - MH Youth Intensive Outpatient - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH

5	Blue Valley Mental Health Center 1121 South 15 Auburn NE 68305	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 225 East 9th Suite 1 Crete NE 68333	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 367 E Street David City NE 68632	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 521 E Street Fairbury NE 68352	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 116 West 19th Street Falls City NE 68355	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 831 F Street Geneva NE 68361	Community Support - MH Outpatient Therapy - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 225 North 4th Hebron NE 68370	Community Support - MH Outpatient Therapy - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 1903 4th Corso Nebraska City NE 68410	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 701 I Street Pawnee City NE 68420	Community Support - MH Outpatient Therapy - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 202 High Street - County Hospital Tecumseh NE 68450	Community Support - MH Outpatient Therapy - MH Youth Outpatient Therapy - MH
5	Blue Valley Mental Health Center 543 North Linden Street Wahoo NE 68066	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH

	Youth Outpatient Therapy - MH
5 Blue Valley Mental Health Center 1100 Lincoln Avenue Suite F York NE 68467	Community Support - MH Outpatient Therapy - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5 CenterPointe 1000 So. 13th Street Lincoln, NE 68508	Community Support - MH Outpatient Therapy - MH Medication Management - MH Day Rehabilitation - MH
5 CenterPointe 2633 "P" Street Lincoln NE 68503	Dual Residential - SPMI & CD ACT Team
5 Child Guidance Center 2444 O Street Lincoln, NE 68510	Outpatient Therapy - MH Therapeutic Consultation - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
5 Community Mental Health Center of Lancaster 2200 St. Mary's Avenue Lincoln, NE 68502	24 Hour Crisis Phone (Regionwide) EPC Services (Involuntary) Community Support - MH ACT Team Day Treatment - MH Outpatient Therapy - MH
5 Community Mental Health Center of Lancaster 2039 Q Street Lincoln, NE 68503	Psych Residential Rehab - MH
5 Community Mental Health Center of Lancaster 2966 O Street Lincoln, NE 68510	Day Rehabilitation - MH
5 Cornhusker Place 721 "K" Street Lincoln NE 68508	Crisis Respite - MH EPC Services (Involuntary)
5 Houses of Hope 2015 South 16th Street Lincoln NE 68502	Intensive Case Management - MH or SA
5 Lutheran Family Services 2900 O Street Lincoln, NE 68510	Emergency Community Support - MH or SA ACT Team Outpatient Therapy - MH
5 Region 5 Systems 1645 N Street Suite A Lincoln NE 68510	Youth Professional Partner - MH

5	St. Monica's Home 4600 Valley Road Suite 450 Lincoln, NE 68510	Community Support - MH Outpatient Therapy - MH
6	Alegent Health, Inc 6901 No. 72nd Street Omaha, NE 68122	EPC Services (Involuntary) Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
6	Alegent Health, Inc Behavioral Health Services 1309 Harlen Drive Bellevue NE 68005	Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
6	Catholic Charities 3300 North 60th Street Omaha, NE 68102	Crisis Assessment/Evaluation - MH Medication Management - MH
6	Catholic Charities 1490 No. 16th Street Omaha, NE 68102	Community Support - MH Dual Residential - SPMI & CD Assessment/Evaluation - MH Medication Management - MH
6	Community Alliance 4001 Levenworth Avenue Omaha NE 68105	Community Support - MH Emergency Community Support - MH or SA ACT Team Day Rehabilitation - MH
6	Community Alliance 616 South 75 St Omaha NE 68114	Day Rehabilitation - MH
6	Community Alliance 6025 Ogden Street Omaha NE 68104	Psych Residential Rehabilitation - MH Day Rehabilitation - MH
6	Community Alliance 3321 Fontellele Blvd Omaha NE 68104	Psych Residential Rehabilitation - MH Day Rehabilitation - MH
6	Community Alliance 2130 South 46 Street Omaha NE 68106	Psych Residential Rehabilitation - MH
6	Community Alliance 2504 South 60th Street Omaha NE 68106	Psych Residential Rehabilitation - MH
6	Community Alliance 2313 North 72nd Omaha NE 68134	Psych Residential Rehabilitation - MH
6	Community Alliance 7233 Pinkney St	Psych Residential Rehabilitation - MH

Omaha NE 68134

- | | | |
|---|---|--|
| 6 | Community Alliance
2904 North 45
Omaha NE 68104 | Psych Residential Rehabilitation - MH |
| 6 | Community Alliance
4901 South 52nd Street
Omaha NE 68117 | Psych Residential Rehabilitation - MH |
| 6 | Community Alliance
2052-54 Deer Park Blvd
Omaha NE 68108 | Psych Residential Rehabilitation - MH |
| 6 | Douglas County Mental Health Center
4102 Woolworth Ave
Omaha, NE 68105-1899 | EPC Services (Involuntary)
Acute Inpatient
Day Treatment - MH
Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH |
| 6 | Friendship Program
7315 Maple Street
Omaha NE 68134 | Community Support - MH
Day Rehabilitation - MH |
| 6 | Heartland Family Services
2101 South 42nd Street
Omaha, NE 68105-2909 | Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Assessment/Evaluation - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |
| 6 | Heartland Family Services
6714 N 30th
Omaha NE 68112 | Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Assessment/Evaluation - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |
| 6 | Heartland Family Services
11212 Davenport Street
Omaha NE 68154 | Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Assessment/Evaluation - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |
| 6 | Heartland Family Services
1246 Golden Gate Drive
Papillion NE 68046 | Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Assessment/Evaluation - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH |

6	Heartland Family Services 116 East Mission Ave Bellevue NE 68005	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Medication Management - MH
6	Lutheran Family Services of Nebraska 120 South 24th Street, Suite 100 Omaha, NE 68102	Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Community Support - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Medication Management - MH
6	Lutheran Family Services 4980 South 118 St Omaha NE 68137	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
6	Lutheran Family Services 2505 North 24th Omaha NE 68110	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
6	Lutheran Family Services 730 North Forte Crook Road Bellevue NE 68105	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Medication Management - MH
6	Lutheran Family Services 403 South 16th Street Blair NE 68008	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH
6	Lutheran Family Services 510 D Street Freemont NE 68025	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Medication Management - MH
6	Lutheran Family Services 1201 Golden Gate Drive Papillion NE 68046	Assessment/Evaluation - MH Outpatient Therapy - MH Medication Management - MH Youth Assessment/Evaluation - MH Youth Outpatient Therapy - MH Youth Medication Management - MH

- | | |
|---|--|
| <p>6 Lutheran Family Services
546 Avenue A
Plattsmouth NE 68048</p> | <p>Assessment/Evaluation - MH
Outpatient Therapy - MH
Medication Management - MH
Youth Assessment/Evaluation - MH
Youth Outpatient Therapy - MH
Youth Medication Management - MH</p> |
| <p>6 Region 6

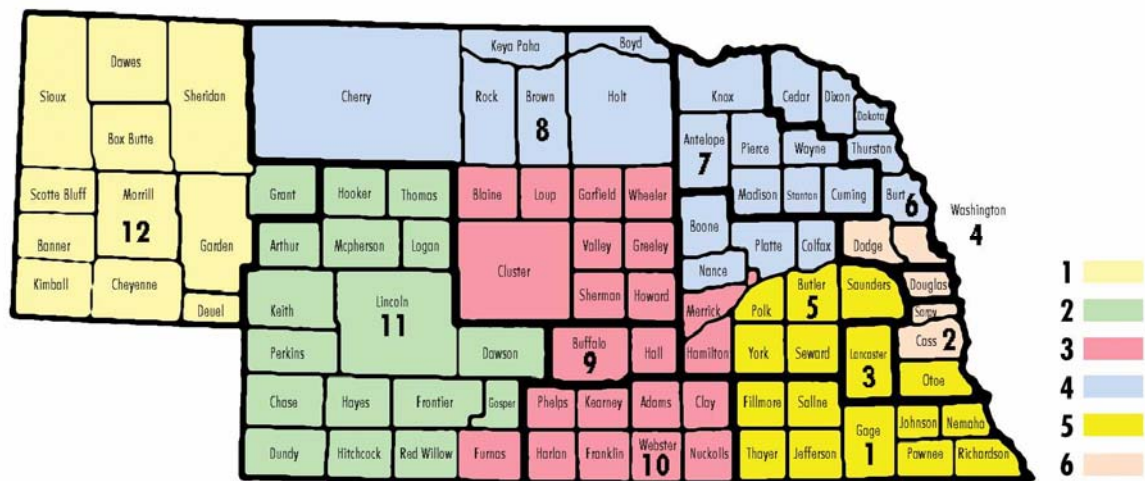
3801 Harney Street
Omaha NE 68131</p> | <p>Youth Professional Partner - MH
Youth Professional Partner School Wrap - MH</p> |
| <p>6 Region 6 Spring Center
3047 South 72nd Street
Omaha NE 68124</p> | <p>24 Hour Crisis Phone (Regionwide)
Crisis Stabilization & Treatment (Voluntary)</p> |
| <p>6 Salvation Army
3612 Cuming Street
Omaha NE 68131</p> | <p>Crisis Respite - MH
Emergency Community Support - MH or SA
Community Support - MH
Intensive Case Management - MH or SA</p> |
| <p>6 Telecare
819 Dorcus
Omaha NE 68108</p> | <p>Subacute Inpatient</p> |

Tribal Programs Funded Direct By Division

- 4 **Omaha Tribe of Nebraska
PO Box 368
Macy NE 68039
- 4 **Winnebago Tribe of Nebraska
PO Box 687
Winnebago NE 68071
- 4 **Santee Sioux Tribe of Nebraska
425 Fraser Avenue No Suite 2 RR 2
Niobrara NE 68760
- 4 **Ponca Tribe Of Nebraska
201 Miller Avenue
Norfolk NE 68701

APPENDIX F

Map of Behavioral Health Regions



APPENDIX G

Warrant of Arrest Form

MENTAL HEALTH BOARD OF _____ COUNTY, NEBRASKA

IN THE INTEREST OF _____)
CASE NO. _____)
WARRANT OF ARREST _____)
Alleged to be a Mentally _____)
Ill and Dangerous Person _____)

TO THE SHERIFF OF _____ COUNTY, NEBRASKA:

The clerk of the District Court for _____ County, Nebraska has received notice pursuant to Neb. Rev. Stat. § 71-939 (Reissue 2004) that (Subject's Name) _____, having been found to be a mentally ill and dangerous person and committed to (Facility) _____, is absent without authorization from that treatment facility or program.

You are hereby commanded to take into custody (Subject's Name) _____ and return him or her to the above-named treatment facility or program or take (Subject's Name) _____ to an appropriate facility until he or she can be returned to such treatment facility or program. This person shall not be placed in a jail.

This warrant may be executed by the Sheriff for _____ County, Nebraska or any other peace officer.

Signed and Sealed this _____ day of _____, 200_.

Clerk of the District Court

By _____

-RETURN-

State of Nebraska)
Lancaster County) ss

The above warrant came into my hands on _____, 200_, at (Location) _____, and I now return it executed, by placing (Subject's Name) _____, at (Facility) _____.

Dated this _____ day of _____, 200_.

_____, Sheriff

By _____
Deputy

Fees: Services & Return _____
Warrant _____
Mileage _____
Total _____

APPENDIX H

Mental Health Individualized Treatment Plan

Board of Mental Health Individualized Treatment Plan
(Inpatient or Outpatient Provider)

Name of Person: _____

Date of Birth: _____ Social Security Number _____

☐ Initial ☐ Supplemental

To: The Mental Health Board of the _____ Judicial District, _____ County,
Nebraska

The above named person is under my care for treatment of _____.
As a qualified mental health professional in compliance with Neb. Rev.
Stat. § 71-906, it is my opinion that this person meets diagnostic criteria for the following mental
disorder(s) and is in need of treatment as stipulated below:

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Patient Clinical Information:

1. _____
2. _____
3. _____
4. _____

Current treatment goals and projected timelines to achieve goals (specify inpatient versus non-inpatient treatment goals):

☐ Hospital Treatment Plan Attached

1. _____
2. _____
3. _____
4. _____

Proposed post-hospitalization treatment plan in the least restrictive environment:

1. _____
2. _____
3. _____
4. _____

☐ Consumer Signature _____
☐ Refused to Sign

Name: _____

☐ The undersigned will **continue** to be the provider of record for this person and will continue to provide care until such time as the care has been transferred to another provider.

_____(Provider
Named) at _____(Address) _____(phone).
The first appointment is scheduled for _____(date) at _____(Time).

All providers agree to follow the expectations of the Board of Mental Health.

Signature: _____ Date: _____

APPENDIX I

Warrant of Inpatient Admission Form

Neb. Rev. Stat § 71-927, 71-928

Revised July 2006 Mental Health Board Training Self-Study
Page 125

APPENDIX J

Outpatient Commitment Order Form

BEFORE THE MENTAL HEALTH BOARD OF THE

JUDICIAL DISTRICT

IN THE INTEREST OF)

CASE NO. _____

ORDER
(Outpatient)

Alleged to be a Mentally
Ill and Dangerous Person
Subject)

This matter comes on for hearing on the _____ day of _____, 200____,
before the _____ Judicial District Mental Health Board.

The (Deputy) County Attorney, _____, was present along with
the subject and the subject's counsel, _____.
The subject acknowledged receipt of a copy of the Petition, Notice of Hearing, list of
Rights and then admitted/denied the allegations of the Petition.

The matter is submitted to the Mental Health Board upon information filed herein, the
testimony elicited, and the evidence that was adduced. Upon consideration thereof, the
Board finds that there is clear and convincing evidence that the allegations in the petition
are true and relies on the following:

The Mental Health Board further finds by clear and convincing evidence that the subject is mentally ill and
dangerous person and neither voluntary hospitalization nor other treatment alternatives less restrictive of the
subject's liberty than a Mental Health Board ordered treatment disposition would suffice to prevent the
substantial risk of harm as described in section 71-908.

Having considered all treatment alternatives, the Board orders the subject placed in the custody of
_____ (name and
address of outpatient treatment facility) for appropriate outpatient treatment. Said outpatient treatment
facility shall prepare and implement an individualized treatment plan for the subject. Said outpatient
treatment facility shall document and report the subject's progress under such plan.

The individualized treatment plan shall contain a statement of (a) the nature of the subject's mental illness or
substance dependence. (b) the least restrictive treatment alternative consistent with the clinical diagnosis of
the subject, and (c) intermediate and long-term treatment goals for the subject and a projected timetable for
the attainment of such goals.

A copy of the individualized treatment plan shall be filed with the mental health board for review and
inclusion in the subject's file and served upon the county attorney, the subject, the subject's counsel, and the
subject's legal guardian or conservator, if any, within five working days after the entry of the board's order.
Treatment shall be commenced within two working days after preparation of the plan.

The subject shall be notified by the mental health board when the board has changed the treatment order or
has ordered the discharge of the subject from commitment.

Said outpatient treatment facility shall submit periodic progress reports to the mental health board detailing
the subject's progress under such plan and any modifications to the plan. The initial progress report shall be
filed with the mental health board for review and inclusion in the subject's file and served upon the county

attorney, the subject's counsel and the subject's legal guardian or conservator, if any, no later than ten days after submission of the subject's individualized treatment plan. Such periodic progress reports shall be so filed and served no less frequently than every ninety days for a period of one year following submission of the subject's individualized treatment plan and every six months thereafter.

Pursuant to NRS Sec. 71-933, said outpatient treatment facility shall report to the board and the county attorney if (a) the subject is not complying with his or her individualized treatment plan, (b) the subject is not following the conditions set by the board, (c) the treatment plan is not effective, or (d) there has been a significant change in the subject's mental illness or substance dependence. The county attorney shall have the matter investigated to determine whether there is a factual basis for the report.

Other:

Legal settlement is found to be _____.

Dated: _____.

MENTAL HEALTH BOARD OF THE
_____ JUDICIAL DISTRICT,

Chairperson

Member/Alternate

Member/Alternate

APPENDIX K

Emergency Protective Custody Admissions Procedure for Dangerous Sex Offender

Unless a medical or psychiatric emergency exists for which treatment at a medical facility is required, a person taken into emergency protective custody who has a prior conviction for a sex offense (sect. 29-4003) shall be admitted to a jail or Department of Correctional Services facility.

EMERGENCY PROTECTIVE CUSTODY ADMISSIONS PROCEDURE FOR DANGEROUS SEX OFFENDER

PURPOSE: To provide emergency care to persons/subjects requiring psychiatric evaluation who are under police custody & BELIEVED TO BE A DANGEROUS SEX OFFENDER, and to facilitate communication between health care providers and law enforcement agencies

PROCEDURE:

If Law Enforcement believes person to be mentally ill and a dangerous sex offender AND the individual is in need of psychiatric and/or medical treatment prior to MHB proceeding:

1. Law Enforcement issues EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER (**Dangerous Sex Offender**) and transported to a **Community Hospital/Crisis Center**.
2. The Law Enforcement Agency will provide the Hospital/Crisis Center staff with a copy of the EPC certificate (EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER) (**Dangerous Sex Offender**) when the subject is brought to the hospital. The copy must be placed in the subject's chart.
3. The Law Enforcement Agency will notify the hospital as soon as possible prior to the subject's arrival whenever feasible. Hospital staff will notify mental health provider, if they were not already notified by the Law Enforcement Agency.
4. Sex offenders must be treated at the hospital in the same manner of any other subject, i.e. A medical provider must be contacted using the regular procedure when a subject with an EPC-Sex Offender order presents to the ER (Emergency Room).
5. Medical/psychiatric stability will be established by a medical/psychiatric assessment and treatment rendered as necessary.
7. All EPC subjects will be entered into the network management system by calling Magellan Behavioral Health and registering subject.
8. Medically unstable subjects will be admitted to the hospital if ordered by attending physician. These subjects may require a guard at their bedside if they are out of control and pose potential for harm to themselves or others. Law enforcement is responsible for providing this protection. The hospital is responsible for identifying medical/psychiatric needs and addressing them with the level of care necessary to maintain safety and promote stability.
9. The Region's Emergency System Coordinator will be notified by phone or by voicemail by contracted hospital staff of admissions within 24 hours, including weekends. Phone

numbers are available from the respective Regional Behavioral Health Office or Regional Program Administrator.

10. Sex offenders with psychiatric/medical conditions must be cared for in the same manner as any other subject in emergency protective custody or under a mental health board commitment.

11. Discharge orders must be written by the medical provider to dismiss or transfer a subject from the hospital. Law Enforcement Agencies may provide additional instructions as needed.

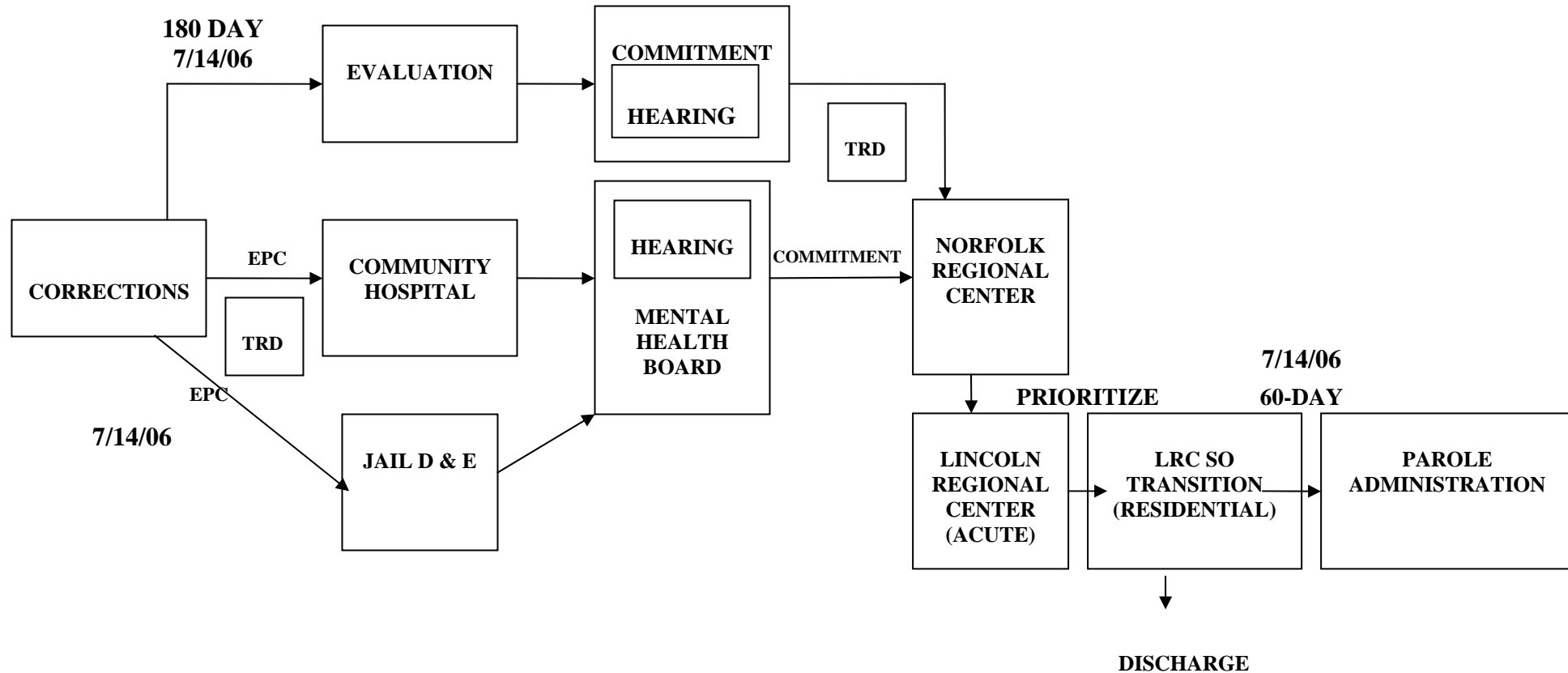
12. EPC-Sex Offender orders can only be lifted by the County Attorney or the Board of Mental Health. Clarify the origin of all orders to lift an EPC.

13. If EPC-Sex Offender subject is going to MHB hearing, the EPC unit (Crisis Center/Hospital) shall notify Magellan (HHS agent) for assistance in securing appropriate Sex Offender Treatment and authorization PRIOR to the hearing. If a subject is committed for either Inpatient or Outpatient services, Crisis Center/Hospital staff must pre-authorize those services. If the service recommended for commitment is inpatient level of care, HHS, Division of Behavioral Health will determine the location of the service provider.

APPENDIX L

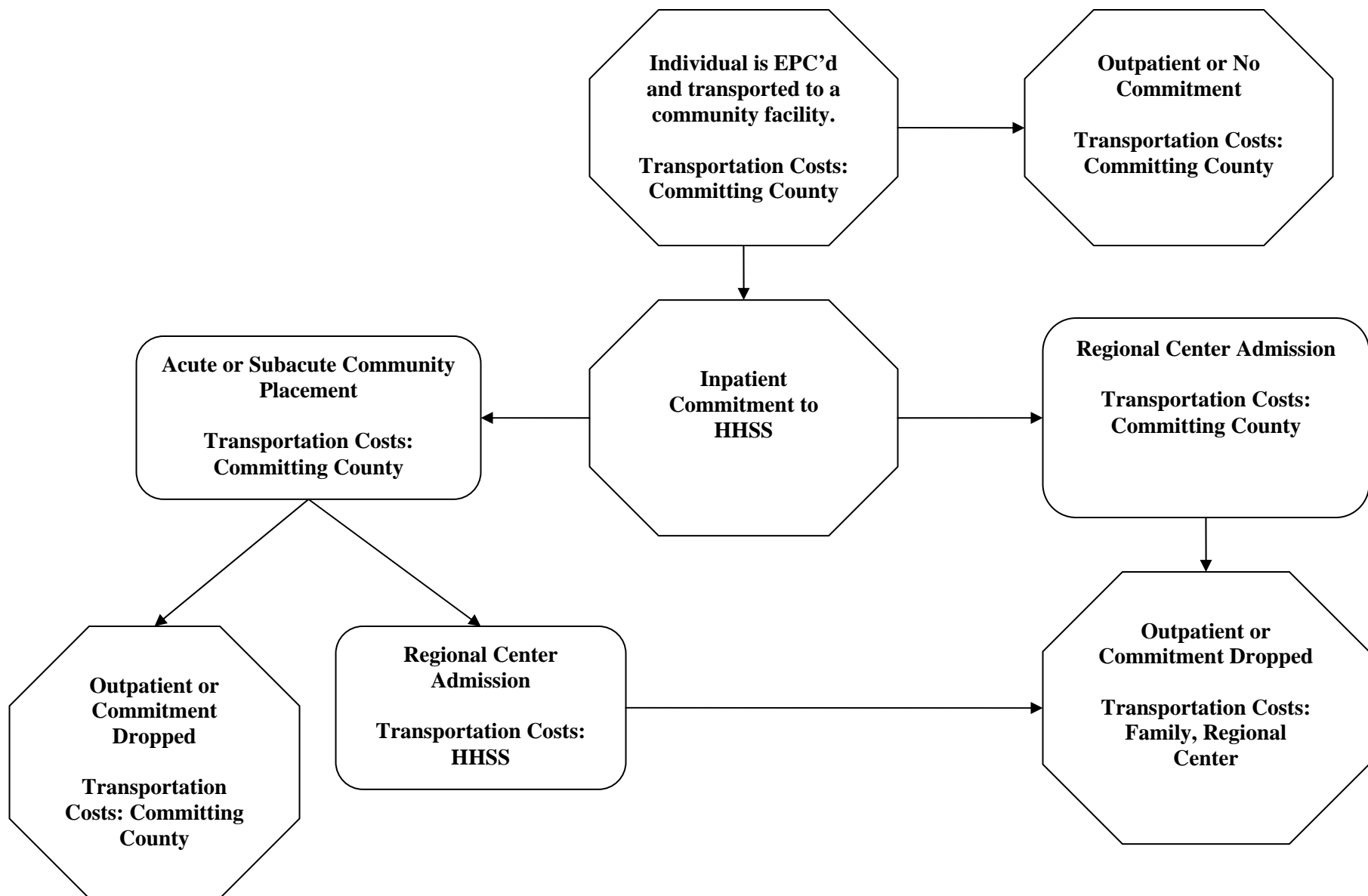
LB 1199 Flow Chart

LB 1199 FLOW CHART



APPENDIX M

Transportation Costs Determination Flow Chart



APPENDIX N

Mental Health Professional Certificate

**Mental Health Professional Certificate
(Dangerous Sex Offender)**

(To be immediately forwarded to the county attorney upon completion-NO later than 24 hours after completion) Neb. Rev. Stat. § 71-1204.

TO: _____ COUNTY ATTORNEY,
OF _____ COUNTY, NEBRASKA

_____, is under my care as a result of an Emergency
(Name & Address of Subject)

Protective Custody placement, upon the certificate of a Law Enforcement Officer. The subject's
evaluation was completed on _____ (a.m./ p.m.) on the _____ day of _____, 200 ____.

☐ _____
(Name & Address of Subject's spouse, legal counsel, guardian or conservator, and next of kin, if known)

☐ _____
(Name & Address of anyone providing psychiatric or other care or treatment to the subject, if known)

☐ _____
(Name & Address of any other person who may have knowledge of the subject's mental illness or personality disorder who may be called as a witness at a mental health board hearing with respect to the subject, if known)

☐ _____
(Name & Address of the medical facility in which the subject is being held for emergency protective custody and evaluation)

As a qualified mental health professional I certify that I have evaluated the subject since the subject was admitted for emergency protective custody and evaluation. It is my opinion that the above subject is a dangerous sex offender and the clinical basis for such opinion is as follows:

The above diagnosis is within a reasonable degree of ☐ psychiatric, ☐ psychological certainty and the Subject presents a substantial risk of serious harm within the near future to ☐ himself/herself, or ☐ others as a result of the above mental illness/personality disorder in the following ways:

It is therefore my opinion, within a reasonable degree of psychiatric,
psychological certainty, that _____ is a dangerous sex
offender as defined by Neb. Rev. Stat. § 83-174.01.

Name of Facility:
Address of Facility:

BY: _____
(Name Certifying Mental Health Care Professional)

ADDRESS: _____

DATE: _____, 200__.

☐ An evaluation was completed within 36 hours of admission and this certificate was executed within 24 hours after completion of the evaluation.

APPENDIX O

EMERGENCY ADMITTANCE PURSUANT TO CERTIFICATE OF A PEACE OFFICER

**EMERGENCY ADMITTANCE PURSUANT TO
CERTIFICATE OF A PEACE OFFICER
(Dangerous Sex Offender)**

To facility authorized by §71-919 to hold the individual who is the subject in custody:

Name of Facility: _____

Address: _____

_____, Nebraska _____

This is to inform you that I, _____, _____,
me of Peace Officer) (Badge Number)

have taken into custody _____
(Name and Address of Subject Taken into Custody)

on the _____ day of _____. I have personally observed this subject

or I have been informed by _____
(Name and Address of a Witness)

_____,
who is a reliable person, and I believe that this subject is a dangerous sex offender as
described below:

Dangerous Sex Offender (Summary of person's behavior supporting such allegations)

The dangerousness indicated above is, in my opinion, likely to occur before Mental
Health Board proceedings can be invoked unless this facility holds the subject in custody
pursuant to this Certificate.

- () Additional police report will be submitted (Reference this placement/admittance)
- () Additional information on the subject's behavior is included in a separate sheet identified as Attachment A which is attached hereto and incorporated herein by reference (Mental Health Professional Certificate).

I am therefore causing this subject to be admitted to your facility.

Date: _____ Signed _____ Badge # _____
(Peace Officer)

Name/Address of Law Enforcement Agency

(_____) _____
Phone

County

This certificate or a copy thereof must be forwarded immediately to the County Attorney.
(Neb. Rev.Stat. §71-919)